Bricolage and BlackBoxing:

Exploring the Responses of Consumers and Health Providers to Controversy about the Third Generation Oral Contraceptive Pill

A thesis submitted in fulfilment of the requirements for
the Degree of
Master of Arts
in Sociology
at the
University of Canterbury,
Christchurch,
Aotearoa/New Zealand

By Jennifer Sarah Hester

University of Canterbury
2001

I think that all happiness depends upon the energy to assume the mask of some other self; that all joyous or creative life is a rebirth as something not oneself, something which has no memory and is created in a moment and perpetually renewed.

(Yeats, W. B. 1928, *The Death of Synge and other Passages from an Old Diary*, Macmillan, London)

ABSTRACT

In the late 1990s, when otherwise healthy women in Aotearoa/New Zealand started to die as a result of thrombosis allegedly attributed to third generation oral contraceptive pills, the workings of this particular version of contraceptive technology (and for many users 'the pill' and other contraceptive methods in general) became subject to scrutiny and re-investigation. This thesis examines the 'talk' of a small selection of contraceptive consumers and health providers in Christchurch, New Zealand who were aware of this contraceptive debate. Through conversations with this study's participants it is possible to trace the discursive practices, responses and strategies taken before and during this medical controversy.

The voices of consumers dominate this thesis and it is my contention that their 'talk' can be interpreted as the deployment of what I call 'bricolage'. Bricolage as practice can be illustrated by paying attention to the self-stories that some contraceptive consumers utilise to constitute themselves and their actions. Contraceptive consumers, particularly during a medical controversy, are exposed to multiple sources of information. They engage in the production of the self with whatever resources they find 'at hand'. My focus is on the practice of bricolage as subjects constitute their selves in and through the varied, often incommensurable, discourses with which they come into contact. I argue that 'bricolage' is a strategy that is utilised when contraceptive consumers want to ensure that they are not constructed as passive, 'blind consumers', but as proactive users who make 'informed choices' and take meaningful action.

This thesis attempts neither to uncover what 'really' happened before and during this contraceptive controversy, nor does it reach conclusions about the medical and statistical 'safety' of oral contraceptives. On the contrary, this study is an exploration of discursive practices: the layering of accounts and the innumerable versions of the same controversial events. While I am interested in the meanings that differently positioned 'actors' ascribe to this controversy, I recognise that access to meanings – such as explanations of 'real' physiological side effects – are mediated though discourses. This is not to deny the 'vital signs' of corporeality, but to contest the supposed transparency of 'experience'. These, then, are the primary approaches that this thesis adopts in order to engage with the strategies utilised by this study's participants when they are coming to terms with the controversy surrounding third generation oral contraceptives.

DEDICATIONS

This thesis is dedicated to three special people:

NANCY: my paternal grandmother's sister who died (9 February 1968) from a pulmonary embolism after a 'blood clot' lodged in her lungs as a result of taking the original formulation of the pill.

IMA AND ABA: my mother and father who gave me the gifts of education, being Jewish and having sufficient 'chutzpah' to attain achievements.

ACKNOWLEDGEMENTS

A central metaphorical figure in this thesis is the bricoleur. Just as many of this study's participants have made sense of the third generation oral contraceptive debate through a process that I refer to as bricolage, I, too, have crafted a piece of writing that draws from seemingly disparate bits and pieces, transforming them into this document. This thesis itself is a type of bricolage: borrowing from other textual sources, threading strands from poetry, social 'science', medico-law and medicine. More importantly though, these two pages are an indication of my gratitude to the human sources who have contributed to my project. A bricoleur is always indebted to the input of other individuals.

First, then, I must recognise those crucial individuals, the participants, without whom this study could not have proceeded. Thank you all sincerely for sharing with me your stories, thoughts and feelings about a sensitive and potentially contentious topic. I hope that those of you who are contraceptive consumers (re)craft yourselves and your bodies so that you can resist the 'blind consumer' position.

It is also essential to mention the tremendous support that I have received from the Ryoichi Sasakawa Young Leaders' Scholarships Programme – through Massey University - and the NZFUW (Inc.) Canterbury Branch Trust Board Masters Scholarship. These scholarships have greatly assisted the research process. Had I not succeeded with these scholarships, it is unlikely that I would have been able to fulfil my academic studies this year. I am certainly greatly indebted.

I am also infinitely grateful to my supervisors: Rosemary du Plessis, Jessica Johnston and Keiko Tanaka. As a newcomer to the sociology department, I was anxious about having never worked with either du Plessis or Tanaka before. I am thrilled to say that my fears were allayed because both of these academics have provided fantastic academic and emotional support. I truly do not believe that this thesis could have progressed without their advice and positive feedback.

Thank you to Jessica for accepting a supervisory role late in the research and writing process. In her usual style, she provided abundant encouragement and enthusiasm. Her comments were particularly useful given that she had not been involved in the research process. Therefore, her 'outside' perspective enabled her to provide extremely helpful suggestions which enhanced the thesis, especially in terms of conceptual expression.

I particularly want to thank Rosemary for the ease with which she encouraged my dishevelled thoughts to reach 'fecundity'. Finally, I want to thank Rosemary for understanding the materiality of corporeality whereby we write through our bodies. Without this recognition, her sympathy for my ongoing back pain would not have existed.

Since academic production is such an embodied act, my bodily pains have often necessitated assistance from all my parents: Sue, Dave, Malcolm and Joyce (Gran). These people are not only my "research assistants" (a phrase coined by Ima), but also my unfailing support network. I am certainly fortunate to have so many parents! Thank you to Aba who listened patiently to the same anxieties and self-doubt every year, while providing endless words of encouragement. Thanks Gran for all your yummy meals and for being so proud of your granddaughter.

Thank you to Karl Willoughby who lived with me and, thus, this thesis. He consistently encouraged me through sleepless nights and listened intently to my ramblings. He might just be able to squeeze a few words in now!

Another constant source of inspiration is my friend, teacher, and role model Bat-Zion Susskind. If ever my energy was waning, her 'chutzpah' certainly sparked a few more pages. Her continual efforts to impress upon me the importance of being proud of my Jewish lineage has encouraged me to (tell everyone!) and write these opening pages in our tongue, Hebrew, in order to locate my Jewish self from the outset. My grandparents hid their Jewish identities through fear of persecution. I am rediscovering and recreating myself by recognising the presence of strong Jewish connections. Language and culture are inextricably connected, consequently, it is very important to me to have some indication of this part of myself in the thesis. Many thanks must go to Batzi for her extensive, expert help with the translation.

Finally, I want to thank those people who have helped me to survive the research process; some of you have helped on more than one occasion. Thanks must go to John Newton for his guidance, wisdom, advice, and for providing new academic challenges. Many of the quotes and metaphors in this thesis he will, doubtless, recognise. Kate Pennell must be acknowledged for her sound advice about creating the foundations for my house first and then painting the rooms, to paraphrase her metaphor. Thanks Kate, this approach worked well! Obviously, my sincere thanks must go to Raanan Eichler, who provided me with not only support and translations, but also such esoteric comments that he has surely secured his place as an important member of The Nation. Chris surely deserves a huge thank

you for being extremely reliable (even on sunny days!). Many of my computer's mysteries were solved by instructions from Chris whilst at his position on the deck! Rebecca Robinson needs to be thanked too for all the disembodied, email advice that she provided on how to be an organised and efficient worker. Pete and Rosie have similarly supported me from afar. So I thank them both as well. I also want to indicate my gratitude to Aunty Mary for her extensive help locating media articles and to Lynne Batty and Sarah Bickerton who found such documents as well.

In keeping with bricoleur styles, these acknowledgements can be conceptualised in eclectic fashion, rather than in a hierarchical and linear manner. In other words, the people who appear in the middle or at the 'end' made no less valuable contributions than those people who are acknowledged at the 'start'.

Jennifer Sarah Hester
26 October 2001

בלהיות גאה במוצא היהודי שלי עודדו אותי (להגיד לכולם!) ולכתוב את עמודי הפתיחה האלה בלשוננו, עברית, כדי 'למקם' (Haraway, 1991, p.) את העצמיות היהודית שלי בהתחלה. אבות אבותיי הסתירו את הזהות היהודית שלהם עקב פחד מרדיפות. אני מגלה את עצמי ויוצרת את עצמי מחדש בכך שאני מכירה בקיום של שושלת יהודית חזקה. שפה ותרבות קשורות בקשר שאין להתירו, ולכן חשוב מאוד בשבילי שיהיה סימן לחלק זה שבי בתוך התזה. הרבה תודות מגיעות לבתצי על העזרה הנרחבת והמקצועית שלה בתרגום.

כמובן, אני מודה מקרב הלב לרענן אייכלר שנתן לי לא רק תמיכה, אלא גם הערות אזוטריות כאלה שהוא ודאי הפגין את מקומו כחלק חשוב מהאומה.

לבסוף, אני רוצה להודות לאותם אנשים שעזרו לי לשרוד בתהליך החקירה. חלק מכם עזר יותר מפעם אחת. תודות מגיעות לג'ון ניוטון על הדרכתו, חכמתו, עצותיו, ועל כך שסיפק אתגרים לימודיים חדשים. הרבה מהציטוטים והמטפורות בתזה זו הוא יכיר בלי ספק. קייט פנל צריכה להיזכר על עצותיה הנאמנות לגבי ייסוד הבית שלי בראשונה, ואחר כך לצבוע את החדרים, בפרפרזה של המטפורה שלה. תודה, קייט, גישה זו הצליחה! רבקה רובינסון צריכה לקבל תודה על כל עצותיה מרחוק דרך דואר אלקטרוני על איך להיות עובדת מסודרת ויעילה. פיט ורוזי תמכו בי מרחוק בצורה דומה, אז אני מודה גם לשניהם. אני רוצה גם כן להביע את הכרת תודתי לדודה מרי על העזרה הנרחבת שלה באיתור מאמרים בתקשורת, וללין באטי ושרה ביקרטון שגם כן מצאו מסמכים כאלה.

כמו בצורות הבריכולור, יש להבין את הכרות תודה אלו באופן אקלקטי, ולא באופן היררכי ולינארי. במילים אחרות, האנשים שמופיעים באמצע או בסוף תרמו תרומות בעלות לא פחות ערך מאשר האנשים שהוזכרו בהתחלה.

שרה הסטר (זהות יהודית)

ג'ני מקדונלד (זהות 'רשמית')

2000/2001

ABBREVIATIONS

The following list of abbreviations are used throughout this thesis:

CCNM	Canterbury College of Natural Medicine
COC	combined oral contraceptive
FPA	Family Planning Association
IUD	Intrauterine device
NFP	Natural Family Planning
OC	oral contraceptive
OCs	oral contraceptives
2GOC	second generation oral contraceptive
3GOC	third generation oral contraceptive
PE	pulmonary embolism
POP	progestogen only pill
THAW	The Health Alternatives for Women
VTE	venous thromboembolism
WHO	World Health Organisation

CONTENTS

CHAPTER 1

INTRODUCING MEDICAL CONTROVERSIES

> The more people you talk to and the different information that you get, the more you find out by putting it all together. One thing is not enough. It just keeps going. It's like polishing a stone. The more you continue to polish it, the prettier it gets, the more it changes and the more enlightened you become from it.
>
> (Zena, interview 13/9/2000)

The controversy surrounding third generation oral contraceptives (3GOCs) is constructed through many contradictory and opposing discourses. Zena (a woman in her late 20s, who switched from oral contraceptives to Natural Family Planning, primarily as a result of the recent controversy in Aotearoa/New Zealand surrounding 3GOCs) reflects on this debate in one of the interviews I conducted in Christchurch in 2000 as part of my research into responses to this controversy. Her comments suggest that during a controversy people are exposed to different sources of information. Her 'talk' highlights several issues of central concern to this thesis. What strategies do contraceptive consumers utilise when they are confronted with a medical controversy? How do they respond to medical debates about the risks and side effects of pharmaceuticals?

In order to explore the answers to these questions I conducted interviews with a number of young women who had been or were users of third generation contraceptive pills and a range of different health providers. I spoke to eleven contraceptive consumers and seven health providers (three 'conventional' doctors who prescribe oral contraceptives, one community health activist, one Natural Family Planning (NFP) teacher, one 'alternative' practitioner, and one midwife). Since 'informed consent/choice' consistently appeared as a highly significant theme throughout all the interviews, I also decided to interview a solicitor well versed in medico-legal issues.[1] This thesis attends to contraceptive consumers' and health providers' 'talk' about the third generation oral contraceptive controversy and their responses to it. Using a variety of conceptual tools, I offer an analysis of the discursive practices of the consumers and health providers who participated in this study.

The purpose of this introductory chapter is twofold. First, it will introduce the medical controversy at the centre of this thesis: the debate surrounding the safety of third generation oral contraceptives. Secondly, it will tease out the pivotal agendas of this thesis through analysing some of Zena's 'talk' during an interview about her responses to a public controversy about the side effects and risks of third

generation oral contraceptives. Although I recognise that not all the contraceptive consumers who participated in this study respond as Zena (interview 13/9/2000) does, many other women I interviewed about the 3GOCs deploy a strategy of putting together disparate pieces of information. I refer to this strategy as 'bricolage'.[2] This process primarily involves contraceptive users constructing themselves as proactive consumers who collect and recombine disparate information that is readily available in order to make expeditious decisions about future contraceptive use.

There are many stories that could be told about the 3GOC controversy. What particular story gets voiced is dependent on the person's positioning. Controversies about the pill, and contraception in general, have a lengthy trajectory in Aotearoa/New Zealand.[3] For example, as Bunkle (1992) points out in her article on Copper 7, there has been adverse information and debate about OCs and Copper 7 for years. In the 1960s when there was publicity about the risks of the original OC, the sales of OCs dropped dramatically (Bunkle, 1992, p.100). Stories about the current 3GOC controversy are set within historical stories of similar medical controversies. In the media, contraceptive controversies are typically framed in terms of drama, loss and the statistical probabilities of risk.[4] These media stories are embedded in other stories which are told within alternative frames.

My own personal involvement in the 3GOC controversy, as a consumer of this formulation of the pill, provided the impetus for this study. I had used a selection of second and third generation OCs sporadically for six years. Mercilon, which is a third generation formulation, was the main OC that I used. For a reasonable length of time I had been experiencing dizziness and fainting. Upon consultation with a Christchurch health organisation, I was advised that Mercilon was "very safe", especially in comparison to 2GOCs, and that the cause of my symptoms was irregular sleep patterns and stress.

As these health problems were escalating, I saw a section on *20/20* (Sunday 28 February 1999) that interviewed the people who were close to women who had died as a result of blood clots attributed to 3GOCs. This programme made me aware that this debate was not confined to Aotearoa/New Zealand, but that it was an international controversy, involving the United Kingdom and Germany in particular. The *20/20* programme also compelled me to investigate the possible links between my own health problems and use of 3GOCs. Only days later, I visited many different health providers, including a naturopath, general practitioner and a doctor at the Family Planning Association. The typical response of these health professionals was to issue me with a handout provided by *Medsafe* for consumer use which outlined

the relative risks of OCs and blood clots.[5] I was also advised that I did not have a high risk of blood clotting attributed to 3GOCs because of the absence of this in my family's medical history. However, I was dissatisfied with this advice, because, for me, although the controversy was about the risk of blood clots, my concerns were interconnected with my own contraceptive history and, in particular, whether there was a relationship between my pill usage and fainting and dizziness. In order to explore these issues further, I consulted more health providers, started to do my own research on the internet, in libraries and by talking to family and friends who used the pill.

The media brought the 3GOC controversy to my attention. Although the 3GOC controversy could arguably be said to have started in 1995, with the publication of five international epidemiological studies (WHO, 1995a; WHO, 1995b; Jick *et al*, 1995; Bloemenkamp *et al*, 1995; Spitzer *et al*, 1995), there was an explosion of media coverage of this debate in 1999. It is hardly surprising, then, that my personal chronology highlights 1999 as the start date of the controversy.[6] The 1999 newspaper articles typically construct the debate in terms of the drama and loss associated with the deaths attributed to 3GOCs (McNeil, *The Press*, 5 March 1999; NZPA, *The Press*, 25 January 1999; Miriyana, *Sunday Star Times*, 7 March 1999). The media also contrast doctors' advice to consumers that they avoid 'panic' responses (Hoby, *The Press*, 26 January 1999; NZPA, *The Press*, 8 March, 1999), with emotive articles centred on OC users' responses to the debate (Miriyana, *Sunday Star Times*, 11 July 1999; Miriyana, *Sunday Star Times*, 2 May 1999).

The focus in the majority of the media articles was on the particular medical risk (thrombosis attributed to 3GOCs) that was the starting point of the controversy and the basis of many consumers' concerns about 3GOCs and OCs in general. The issue at the centre of the 3GOC controversy concerned the relationship between the use of oral contraceptives and venous thromboembolic disease.

Venous thrombosis is the collective term used to describe the related diseases, deep vein thrombosis and pulmonary embolism (Sartwell & Stolley, 1982). A clot develops in an additive process and may result in the occlusion of the affected blood vessel. Venous thrombosis may occur in the superficial or deep veins and tends to affect the lower limbs, especially the calf. Symptoms, if any, may include pain, muscle tenderness and swelling of the affected leg (Sartwell & Stolley, 1982). Pulmonary embolism is a potentially fatal event which may arise from deep vein thrombosis. Embolisation occurs when a thrombus (or part of one) is dislodged from

the point of attachment and travels through the venous system to the pulmonary arterial circulation (Greaves & Tabener, 1996; Ledingham & Weatherall, 1996).

Numerous epidemiological studies (Stadel, 1981) had shown that the use of any combined oral contraceptive was associated with a four to eleven-fold increase in the risk of venous thromboembolism (VTE) over non-use. The thrombogenicity was originally thought to be associated with oestrogen content (Edwards and Cohen, 2000). Subsequent reports, such as the 1995 epidemiological studies, have indicated that oral contraceptives containing the newer progestogens, desogestrel and gestodene (3GOCs contain these), are associated with a higher risk of VTE than older formulations. The findings of the 1995 studies led to considerable controversy. In the medical community, the debate focussed on whether the results of the research represented a causal relationship, or whether the results could be explained by bias or confounding (Egermayer & Roke, 2000; Edwards & Cohen, 2000).

Pharmac (The Pharmaceutical Management Agency, a Crown entity, directly accountable to the Minister of Health and which manages pharmaceutical subsidies in Aotearoa/New Zealand) was also concerned with assessing the epidemiological 'evidence'. For example, in an article released by Pharmac in the *New Zealand GP* magazine (26/4/1999), the headline 'Emotion vs Fact: the Drug Marketing Game', suggests that their focus in the controversy was on evaluating the physiological 'evidence' and 'facts' in order to assess whether 3GOCs have a higher risk of VTE than older formulations of the pill. This article questions what type of information about the risks of OCs can be considered "reliable and accurate" given that a lot of pharmaceutical marketing stems from drug companies which could contain "bias". In *For Health or Profit: Medicine, the Pharmaceutical Industry, and the State in New Zealand*, Peter Davis (1992) also questions whether the pharmaceutical industry is a disinterested partner for the clinician and he argues that this industry is not devoid of social and moral colouring. He creates a tension between health and profit in terms of the type of information, especially in advertising, that is generated by pharmaceutical companies.

In addition to the different, often conflicting, information circulating, the 3GOC controversy was also particularly pivotal in Aotearoa/New Zealand because this country appears to have one of the highest levels of prescribing of the implicated OCs in the world (Carnall *et al*, 1995). In early 1995 before the controversy, 3GOCs represented between 75-80% of the total OC market in Aotearoa/New Zealand (Aggett, 1997); whereas, 3GOCs represented about 53% in

the United Kingdom, 33% in Norway, 40% in the Netherlands, 15% in United States and Canada and only 5% in Australia (Farmer 1997). The particularly low use in Australia might be primarily due to the cost because 3GOCs are not subsidised in Australia.

In contrast to Australia, all oral contraceptives in Aotearoa/New Zealand are at least partially subsidised by the government (Pharmac, 1996; Pharmac, 1998). The cost of these pharmaceuticals depends on the brand of the pill and the consumer's circumstances. For those women who are not prescribed a fully subsidised pill, or who have not been granted Special Authority,[7] a three month prescription costs the consumer approximately $9.50 - $11.50 (Pharmac, 1998). The introduction of fully subsidising OCs was part of a government initiative aimed at improving access to contraception. For example, in August 1998, Pharmac provided full subsidy to two more OCs: Monofeme and Trifeme (article, 15/7/1998, www.pharmac.govt.nz).

In 1995, 3GOCs were available to consumers at the same price as the older formulations (Egermayer & Roke, 2000, p.52). Subsequent to the 3GOC controversy, 2GOCs attracted a higher subsidy from Pharmac than 3GOCs (Edwards and Cohen, 2000). In addition, following the controversy, the market share of 3GOCs in Aotearoa/New Zealand dropped from 76.8% in 1995 to 31.5% in 1999 (Egermayer & Roke, 2000). In countries, such as Aotearoa/New Zealand, where the utilisation of the pill was high, there was a "widespread" shift to 2GOCs (Egermayer & Roke, 2000, p.53). In all countries except Aotearoa/New Zealand and Norway, 3GOCs are again prescribed as the first option, or the "first line" (Egermayer & Roke, 2000, p.53). In their recent article, Egermayer and Roke (January 2000, p.53) indicate that "anecdotal evidence" is suggestive that due to the experience of minor side effects on 2GOCs, some women are resuming use of 3GOCs, despite the current extra cost. Of the eleven women I spoke to for this study, six stopped using OCs in favour of other contraceptive methods and five continued usage of OCs. Half (three) of those who were former OC users, had ceased usage as a result of the 3GOC controversy. The other three had various other reasons, sometimes in addition to the controversy, which contributed to their decisions to change their method of contraception.[8]

For many of the consumers I spoke to, making decisions about whether to continue OC usage did not only revolve around the questions of primary concern to Pharmac and many medical professionals about the relationship between 3GOCs and thrombosis. On the contrary, the consumers who participated in this study made decisions about future contraceptive use based upon, among other things,

the United Kingdom, 33% in Norway, 40% in the Netherlands, 15% in United States and Canada and only 5% in Australia (Farmer 1997). The particularly low use in Australia might be primarily due to the cost because 3GOCs are not subsidised in Australia.

In contrast to Australia, all oral contraceptives in Aotearoa/New Zealand are at least partially subsidised by the government (Pharmac, 1996; Pharmac, 1998). The cost of these pharmaceuticals depends on the brand of the pill and the consumer's circumstances. For those women who are not prescribed a fully subsidised pill, or who have not been granted Special Authority,[7] a three month prescription costs the consumer approximately $9.50 - $11.50 (Pharmac, 1998). The introduction of fully subsidising OCs was part of a government initiative aimed at improving access to contraception. For example, in August 1998, Pharmac provided full subsidy to two more OCs: Monofeme and Trifeme (article, 15/7/1998, www.pharmac.govt.nz).

In 1995, 3GOCs were available to consumers at the same price as the older formulations (Egermayer & Roke, 2000, p.52). Subsequent to the 3GOC controversy, 2GOCs attracted a higher subsidy from Pharmac than 3GOCs (Edwards and Cohen, 2000). In addition, following the controversy, the market share of 3GOCs in Aotearoa/New Zealand dropped from 76.8% in 1995 to 31.5% in 1999 (Egermayer & Roke, 2000). In countries, such as Aotearoa/New Zealand, where the utilisation of the pill was high, there was a "widespread" shift to 2GOCs (Egermayer & Roke, 2000, p.53). In all countries except Aotearoa/New Zealand and Norway, 3GOCs are again prescribed as the first option, or the "first line" (Egermayer & Roke, 2000, p.53). In their recent article, Egermayer and Roke (January 2000, p.53) indicate that "anecdotal evidence" is suggestive that due to the experience of minor side effects on 2GOCs, some women are resuming use of 3GOCs, despite the current extra cost. Of the eleven women I spoke to for this study, six stopped using OCs in favour of other contraceptive methods and five continued usage of OCs. Half (three) of those who were former OC users, had ceased usage as a result of the 3GOC controversy. The other three had various other reasons, sometimes in addition to the controversy, which contributed to their decisions to change their method of contraception.[8]

For many of the consumers I spoke to, making decisions about whether to continue OC usage did not only revolve around the questions of primary concern to Pharmac and many medical professionals about the relationship between 3GOCs and thrombosis. On the contrary, the consumers who participated in this study made decisions about future contraceptive use based upon, among other things,

their contraceptive histories and personal biographies and their 'experiences' of side effects other than thrombosis, such as headaches, acne, mood changes and weight gain. Due to the nature of the controversy, the consumers I interviewed were exposed to multiple sources of information. Rather than paying attention only to the epidemiological evidence, many of the consumers I spoke to also utilised other knowledges such as media publications, internet articles, conversations with family, friends and 'alternative' health providers.

This thesis focuses on exploring the responses to the 3GOC controversy that can be garnered from the interviews I conducted with consumers or former consumers of oral contraceptives. I argue that the process suggested by Zena (interview 13/9/2000) can be interpreted as 'bricolage'. Bricolage as practice can be illustrated by paying attention to the self-stories that some contraceptive consumers utilise to constitute themselves and their consequent actions. They engage in the production of self with whatever resources they find 'at hand'. My focus is on subjects' practices of bricolage as they constitute their selves in and through various discourses with which they come into contact.

Zena (interview 13/9/2000) discusses the possibility of reworking the different pieces of information that she has collected. For example, she says that it is possible to understand an issue more fully by speaking to different people, gathering various pieces of information and "putting it all together". More importantly, she explains that: "One thing is not enough". Another way to express this is to say that the traditional quest for one epistemological truth is inadequate when attempting to come to terms with an issue. Zena suggests that medical information by itself is "not enough" when OC users try to make sense of an issue such as the recent 3GOC controversy. Zena is clearly promoting a multiplicity of information, that I call 'bricolage' (which includes a collection of knowledges[9]) as opposed to knowledge. The practice of bricolage as it is utilised by many of the consumers interviewed for this study is explored in Chapters Three and Four. Bricolage allows not only new possibilities, but also expanded understandings. Although many of the OC users - whose voices dominate this thesis - invoke statistical knowledge during their sense-making strategies, they also pay attention to other information, such as their personal contraceptive histories and embodied 'experiences', in ways that many health providers do not.

This seeming delineation between health providers' attention to knowledge as opposed to contraceptive consumers' utilisation of knowledges is potentially misleading. I do not want to argue that OC users comprise a homogeneous group

which is entirely distinguishable from the 'other' group: the health providers. Neither am I suggesting that these two groups exclusively operate with contrasting epistemologies. On the contrary, my point is that during a controversy, although differently positioned people reinstate their identities and vigorously draw boundaries between competing knowledge claims, a closer analysis of their 'talk' highlights the fluidity, instability and changeable nature of selves and knowledges. Given this state of flux, the consumers and health providers I interviewed often occupy multiple selves simultaneously.

One of the purposes of this thesis is to unpack the, often contradictory, discursive tactics utilised by a self-selected group of consumers and health providers who were aware of the 3GOC controversy. Prior to a controversy, it might appear that people's 'identities' and epistemological foundations are singular and stable. It is during a debate that the epistemological assumptions underlying differently positioned people's statements and responses become visible. I trace this process of constituting subjectivities which is highlighted through an examination of the discursive practices of the contraceptive consumers and health providers interviewed for this study. How are matters of 'fact' debated? Can a matter of fact become definitively established? What happens to 'facts', selves and bodies during a controversy? How do people involved in a medical controversy respond? What strategies, if any, do they deploy? These are a few of the primary tasks of this thesis.

My interest in the ramifications that flow from the ways that people position themselves and gather and utilise information within the 3GOC controversy was conducive to a semi-structured interviewing methodology.[10] I considered that a qualitative technique, which facilitates in-depth 'talk', was suitable for my primary purposes: to explore the meanings and discursive constructions surrounding the 3GOC debate and their resultant actions. Although I did conduct interviews armed with a potential list of questions and themes,[11] participants often initiated the direction of the dialogue. They regularly discussed meanings about issues that disrupted my preconceptions and raised ideas that I previously thought "didn't fit" (Becker, 1998). For example, my preliminary readings argued that consumers privilege experiential information (Williams & Popay, 1994; Stacey, 1994; Tuckett *et al*, 1985; Arksey, 1994). However, while transcribing, I realised that the narratives "didn't fit" this type of analysis. I decided to pay attention to this anomaly. The result was my argument that consumers do value experiential knowledges, but they also draw on a variety of sources and recombine them in order to understand an event. These were/are the sorts of meanings that I was/am interested in and which

are explored in Chapter Two of this thesis. This chapter explores the methodological assumptions that informed this research. It is followed by a chapter that provides a detailed discussion of the key theoretical tools that are used in my analysis of the interviews I conducted with a small number of consumers and health providers.

In Chapters Four and Five I illustrate the practice of bricolage through an analysis of the risks associated with OCs. In Chapter Four I also explore what information is valued by differently positioned people during a controversy. However, the focus in this chapter is on bricolage in action. I enquire into how information circulates, how it is accessed and what consumers do with it. I point out that many of the contraceptive users I spoke to consider medical/quantitative information alone to be inadequate. A bricolage strategy is undertaken whereby consumers patch together this knowledge and other knowledges such as magazine and newspaper articles, television programmes, conversations with friends and family, bodily signs and internet information. Despite an effort to circulate and re-establish certain knowledge about OCs through devices such as government constructed user leaflets, the contraceptive consumers I interviewed do not passively rely solely on this information. Rather, they access, interpret and mould various types of information. The knowledge contained within these leaflets is often embedded within their understanding of everyday, lived bodily 'experiences'. Indeed, it is clear that this active recrafting of such objects enables the consumers in this study to feel empowered and proactive and, thus, to contest their depiction in the media as 'victims' of biotechnology.

In Chapter Five, the analysis in Chapter Four is developed through a troubling of the notion of 'informed consent'. In particular, I argue that the consumers I spoke to constitute themselves as 'informed' once they have collected a mélange of knowledges, rather than just 'official' information. I explore the relationship between the legal and medical notion of 'informed consent' and the construction of a proactive health consumer who is resistant to passivity and docility.

The mutations which I am contending occur during the 3GOC controversy, are indicative of the contested character of meanings. I trace the disputes over meaning that are played out in transcripts of the interviews I conducted and a modest selection of media documents. Certain meanings are strategically deployed in order to designate boundaries. As I have already noted, often a particular type of knowledge/meaning is marked via a material entity such as a government pamphlet. To illustrate, doctors typically appeal to statistical 'evidence' when trying to

minimise the risks allegedly associated with OCs. By contrast, the meaning of risk for OC users and so-called 'alternative health practitioners' is often endowed with variable meanings.

This existence of multiple meanings with respect to OCs does not imply that each definition is accorded an equal standing with others. Certain meanings are frequently legitimised at the expense of other knowledges. Once a particular meaning is valued to the detriment of others, certain consequences follow. For example, when the State decided that 3GOCs were safer than older formulations of OCs, they subsidised these pills (Doctor X, interview 14/9/2000; Ketting, 1996). In addition, many general practitioners preferentially prescribed 3GOCs because they also considered that the safety of 3GOCs was an incontrovertible 'fact'. Clearly, then, the prevailing meanings ascribed to 3GOCs – and the privileging of a certain definition of the risks associated with 3GOCs – have practical consequences that are not isolated to mere textual, discursive battles.

Claims relating to a multiplicity of meanings and knowledges are political and have theoretical implications.[12] Opponents of postmodernism/ poststructuralism[13] (MacKinnon, 2000; Waters, 1996; Klein, 1996; Thompson, 1996; Spretnak, 1996) worry that embracing these theoretical impulses will result in a denial of the material and an undermining of identity politics and relativism. Due to this hostility to poststructuralism and postmodernism, I have chosen to use insights drawn from poststructuralist theories with *some* trepidation. Indeed, I have even endured anxieties about applying these 'theories' to such a thorny issue as the 3GOC debate where women have died and experienced 'real' side effects.[14] In Chapter Three, I outline both the concerns that I had regarding the use of some poststructuralist and postmodernist ideas and also the inimical reaction that an uptake of these orientations sometimes receives.

I decided that an analysis of the 3GOC controversy in terms of these sets of ideas is not problematic. My specific worry was that attention to the discursive would negate users' bodily 'experiences'. I am, however, convinced that to examine meanings is not to deny the material, in this case, users' 'vital signs' of physicality. For instance, when an OC user has a headache as a result of the pill, these physiological signs are not ignored. My focus, however, is on the meanings given to this corporeal experience. And what a headache means, or how it is understood, is mediated through the discursive.

My choice of methodology was significant not only because of my focus on the discursive, but also due to the dearth of qualitative material on this topic. I was unable to locate the work of any social scientists on the 3GOC controversy that began in 1995, but received most media exposure in 1998 and 1999. In addition, the majority of literature that canvasses contraception or OCs, in general, is quantitative and located within a medical paradigm (Egermayer & Roke, 2000; Edwards & Cohen, 2000; WHO, 1995a; WHO, 1995b; Jick *et al*, 1995; Bloemenkamp *et al*, 1995; Spitzer *et al*, 1996; Farmer *et al*, 1997). The same applies to the literature that pertains to these areas in the social sciences. Here, too, investigations have been mainly quantitative analyses (Coulter, 1985; Marks, 1999; Pool *et al*, 1999). This thesis utilises a different orientation which conceptualises embodiment and pain as multifaceted rather than the sole creation of anatomy and physiology (Williams & Bendelow, 1998). It is my hope, therefore, that this thesis provides a starting point for further qualitative investigations into some of the issues surrounding the recent 3GOC controversy.

A qualitative approach seemed essential to glean an insight into a selection of consumer 'stories' about the impact of the 3GOC controversy. It is these knowledges that are often excluded from 'official' accounts, such as the pamphlets and information sheets on OCs. Consequently, consumer 'stories' dominate this thesis. As Zena's (interview 13/9/2000) quote at the beginning of this chapter indicates, it is this 'storytelling' which is crucial during such a controversy. She explains that "you can't talk about things too much" (Zena, interview 13/9/2000). She goes on to say that this process is healing because it facilitates you "dealing with it" and "moving on" (Zena, interview 13/9/2000). It is not unusual for consumer 'stories' to blend past occurrences and future anticipations into their reconstructions of the meanings surrounding the 3GOC controversy. They respond to this contemporary debate in terms of their own life histories of using the pill and other contraceptive methods. The knowledge that they draw on may contain medical elements from doctors, medical pamphlets or the media, but the sense-making associated with it is always embedded within their particular biographies. As a result, their stories often resist a linear path, preferring instead to blend present, future and past. In Zena's (interview 13/9/2000) words, talking about a controversy produces "something new" each time. She concedes that the historical "old issues and parts are still there but there are new ones too" (Zena, interview 13/9/2000). Her mixing of time frames allows her to recraft the 'current' debate in terms that make sense to her.

This troubling of linear conceptions of past – present – future has implications for the 3GOC debate. Many health professionals give this ongoing debate a narrow definition. For them, it is solely about 3GOCs and the 'relative risk' of thrombosis. Granted, some prescribers do set this latest 'pill scare' in the context of earlier 'scares', but they do so in different terms. Their framing, however, fails to address a plethora of wide ranging issues that are not simply confined to 3GOCs and thrombosis. For instance, in contrast to health professionals' tendency to focus exclusively on quantitative medical information, many of the consumers I interviewed located this controversy in their personal histories of contraceptive use and their future plans. For instance, Ginny's (interview 31/8/2000) comments suggested that contraceptive consumers are often not "surprised" when researchers find "things wrong with the pill" because they have been "waiting to hear something", given that medical studies sometimes simply "verify" (Coney, 1987, p.7) their own bodily responses. Furthermore, for consumers, the 3GOC debate is also simply yet another example of a medical controversy,[15] not necessarily related to contraception. Users' 'storytelling' about this particular debate are invariably embedded within discussions about other, similar medical 'scandals', both public and private. Given this mingling of present, future and past, it is important to traverse the previous 'pill scares' and other medical controversies that have occurred in Aotearoa/New Zealand in order to 'situate' the 3GOC controversy.

As Zena (interview 13/9/2000) relates in this chapter's opening quotation, "old issues" resurface in a new debate. Reworked versions of familiar concerns certainly re-emerge during the 3GOC controversy. For instance, the 1999 3GOC controversy was simply the latest in a string of 'pill scares' which involved many health professionals trying to minimise the risks associated with 3GOCs by setting identified side effects against general, everyday risks. To illustrate, during an early 'pill scare', a 1971 headline quoted Dr Richard Seddon as saying that there was "more risk in [a] car than on [the] pill" (cited in Smyth, 2000, p.146). Similarly, one of the health professionals interviewed, Luxi (interview 13/10/2000), makes analogous comments when she argues that the risks of 3GOCs are "less than if you were driving along the road for two hours without being killed". Luxi reifies a static meaning of the pill in which its risks are dismissed as insignificant.

Conversely, those who are critical of OCs emphasise the side effects associated with the pill. Yet, just as advocates of OCs have reworked old arguments, so, too, have the pill's opponents. This is captured through a comparison of an excerpt from *Broadsheet*, a feminist magazine, and comments made by Peter Kearns (Co-Director and naturopath CCNM, interview 26/8/2000). *Broadsheet* featured

several articles expressing the dangers of the pill's early years on the market. In response to statements which diminished the pill's side effects, Sandra Coney wrote in 1978 (p.7) that:

> If [women] have resisted [use of OCs] and tried other less harmful means of contraception or used none, they are labelled as irresponsible, careless and unintelligent and their fears dismissed with such irrelevant statements as "You're more likely to get run over in the street" or "It's better than being pregnant". These studies show that such statements are lies designed to quell the very realistic fears of women about what they are expected to do to their bodies in the name of "responsibility".

In this extract from *Broadsheet*, Coney discussed contemporaneous British studies that cast doubt on the safety of early OC formulations. Coney polemically called into question arguments which diminished the side effects of the pill by reducing them to "lies". She invoked the study's findings in order to substantiate that OCs were dangerous, something that users had already known "instinctively" (Coney, 1978, p.7) for years. In keeping with this line, Coney deemed the correlation between the risk of getting "run over in the street" with OC usage as "irrelevant". Despite Coney's challenge to the construction of women as "unintelligent" in favour of advocating women's agency, this stance is somewhat irreconcilable with the cartoon that appeared on the same page (see figure 1.1). This image depicted the hypothetical headstone of "Sarah Sacrifice". It symbolised the medical and technological oppression of women in general and, thus, not just the subjugation of women via OCs. In the cartoon's terms, Sarah had sacrificed not "liberated" herself through taking the pill. She paid a "price" for the freedom that the pill supposedly granted her. In fact, the cartoon questioned this assumed freedom further with the headstone's inscription which read that Sarah was "conned, ripped off, cheated on, lied to, used, abused, diseased, deluded, dehumanised, deranged, dead". The "lied to" here certainly echoed and reinforced Coney's earlier sentiment that dismissive statements about OCs' side effects were "lies". *Broadsheet* was certainly contesting claims that medicine and technology free women by contending that this dubious liberation was actually a "sacrifice" which came with costs of long-term medicalisation, potential health-threatening side effects, and a "responsibility" that absolved men from any accountability.

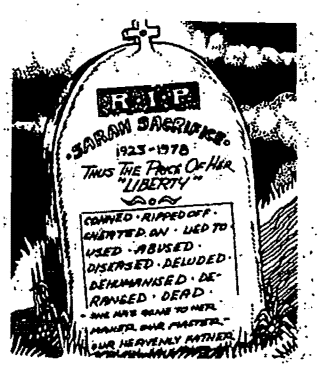

Figure 1.1: *Broadsheet*, 1978, no.57, p.7.

This debate about whether birth control liberates or oppresses users is an "old issue" (Zena, interview 13/9/2000) which continues. The argument that life is full of risks that exceed the risks associated with using the contraceptive pill has been around for some time. It surfaces with each new wave of controversy. On the one hand, feminist publications such as *Broadsheet* have contended that medicine and technology treat consumers as "guinea pigs" (Smyth, 2000, p.94), failing to provide women with promised liberation. On the other hand, there are feminists who suggest that birth control has the potential to liberate women from their biological constraints (Firestone, 1979). My aim at this juncture, though, is to point out that when such issues appear in recent controversies, they are not new. Consequently, when Peter Kearns (Co-Director and naturopath CCNM, interview 26/8/2000) refers to the 3GOC debate and states that women have had a "huge price to pay" through their use of birth control, it is easy to see that this argument is a reworked version of the issues that were raised in *Broadsheet* in 1978. Specifically, "Sarah Sacrifice" paid a price for using early formulations of OCs, just as current users of 3GOCs have a "huge price to pay". Likewise, Coney's troubling of the argument that risking OC side effects is "better than being pregnant" also foreshadows Kearns' assertion that 3GOC debates about the same issue are "foul" because they imply that "pregnancy is more dangerous than the pill" (Peter Kearns, Canterbury College of Natural Medicine, interview 26/8/2000). Undoubtedly, all the aforementioned examples indicate that the recent 3GOC controversy does not exist in a vacuum, but is 'situated' within a history of similar debates about oral contraceptives in which comparable matters were raised.

Indeed, in addition to the 3GOC controversy, other 'pill scares', both national and international, have surfaced at regular intervals since the pill's introduction in the early 1960s.[16] To name a few, fears about thrombosis were first raised in the late 1960s and early 1970s and concerns about the pill's links to breast cancer were debated in the early 1980s. Reports in medical journals have documented the repercussions of previous 'scares'. In 1983, for instance, another 'scare' was supposedly instigated when two studies concerning a possible relationship between early OC use and the development of cervical and breast cancers were published (Grimes, 1990). Earlier in 1969 the Committee on Safety of Drugs in Britain released a statement which highlighted the thromboembolic risk of COCs and recommended the use of lower estrogen[17] doses. By the end of 1970, almost all OCs contained lower doses of estrogen. In Aotearoa/New Zealand in 1977, the Royal College of General Practitioners' study recommended that women over thirty five years of age and who smoked should discontinue OC use. This apparently led to an increase in the number of conceptions and terminations of pregnancies (Ketting, 1996).

Fears about 'pill scares' frightening women into having abortions are similarly raised in the recent 3GOC debate. Underlying such concerns is an assumption that abortion is a grossly inappropriate method of fertility control. However, one Asian participant in this study reported her mother's advice that it is preferable to "just have an abortion if you get pregnant" (Heidi, interview 26/8/2000) rather than risk having "a kid before you're married". Contraception is not always an option in this community because, according to Heidi, "you're not even supposed to be having sex" (interview 26/8/2000). Although Heidi is an "atypical" (Heidi, interview 26/8/2000) Asian and, undoubtedly cannot be considered representative of Asians in general, when I asked her if these circumstances might be similar in other families, she explained that this scenario would hold true for "quite a few". Many Japanese women also consider abortion to be a legitimate contraceptive method (Oaks, 1994; Yokoyama, 1993, 1995; Peter Kearns, CCNM, interview 26/8/2000). Some researchers have highlighted both the legitimacy and high incidence of abortion in Japan (Oaks, 1994) and the relationship between the frequency of abortion and prostitution in Japan (Yokoyama, 1993, 1995). This highlights the cultural specificity of the assumption that abortion is an inappropriate form of fertility control. Given these accounts, it is arguable that under the guise of 'objectivity', many doctors' quantitative explanations and assumptions actually "promiscuously cohabit" (Haraway, 1997, p.68) the same space as culture and subjectivity. In other words, objectivity and subjectivity are not posited in a binary opposition. On the contrary, these concepts overlap, interact and intermingle. They "cohabit" or occupy similar spaces, rather than being isolated to specific realms and/or people.

It would be reductive, however, to suggest that these debates are only contested with the consumers on one side, who are constructed as the 'anti-pill' campaigners, and the 'pro-pill' campaigners, the health professionals and drug companies on the other. These groupings – and their presumed attendant views - do not enjoy such stability. On the contrary, some health professionals have made unequivocal stands against the pill. In her book, *The Bitter Pill: How Safe is the Perfect Contraceptive?* (1985), Dr Ellen Grant calls into question the claim that the pill is a 'wonder drug'. As an illustration, the cover of her book depicts an image of a free-floating packet of OCs in flames (see figure 1.2). A possible reading of this depiction suggests that these drugs should be destroyed, burnt, or, in Paul Holmes' words, "vehemently thrown out" (*Holmes*, 2/6/2000). Just as fire is dangerous and life threatening, so, too, do OCs pose serious and potentially life-taking risks. One such side effect that Dr Grant isolates as "notorious" (p.28) is thrombosis. She

explains that this particular condition was identified early as a highly dangerous risk linked to the pill (Grant, 1985, p.28).

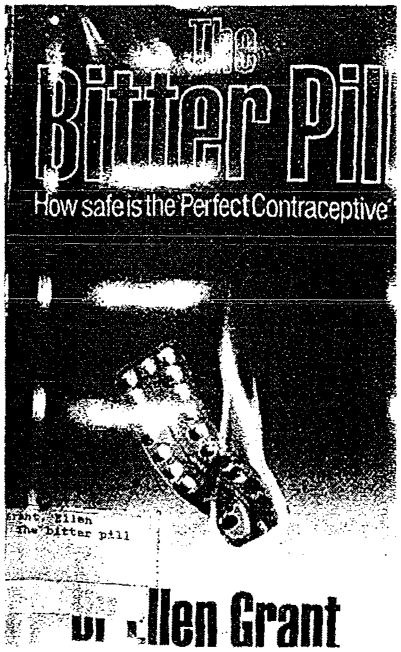

Figure 1.2: Cover of Dr Grant's (1985) *The Bitter Pill: How Safe is the Perfect Contraceptive?*

Just as doctors may oppose the use of OCs, so some consumers may adopt arguments typically advanced by health professionals. For instance, one consumer I interviewed, Jacqueline (interview 25/8/2000), defends the familiar stance that medical technologies, like OCs, indicate that 'we' have "progressed". She continues by claiming that "medicine has given us a lot of valuable knowledge" that should not be rejected under any circumstances unless 'we' want to revert to "primitive times". It hardly needs mentioning that this position is reminiscent of conventional Western medicine arguments. Moreover, the dichotomies that she constructs between West/East, them/ 'we', civilised/ 'primitive', are highly problematic. The dualisms that Jacqueline (interview 25/8/2000) presents here privilege the first term in the hierarchy at the expense of the second. It is through the use of such binary oppositions that the first term maintains itself as the yardstick for the 'other'. Deconstruction defies this type of either/or reasoning (logocentrism). It challenges such schemas by showing that such dualistic thinking is 'leaky' (Shildrick, 1997).

The start date of the current 3GOC controversy is also 'leaky'. Many OC users interviewed (when asked about these dates) responded, again, in terms of their personal histories. Indeed, prior to commencing this thesis, I, too, conceptualised

the 3GOC 'scare' in the context of my own personal trajectory. Consequently, for me, the debate began in 1999 after I watched a programme on *20/20* that explored the topic.[18] By contrast, 'official' versions maintain that the catalyst for this particular 'pill scare' was the publication of five epidemiological studies starting in 1995 (WHO, 1995a; WHO, 1995b; Jick *et al*, 1995; Bloemenkamp *et al*, 1995; Spitzer *et al*, 1996; Farmer *et al*, 1997). This thesis does not attempt to resolve or arbitrate in the 3GOC controversy or to assess this medical 'evidence'.[19] Therefore, in this section I canvass (describe rather than analyse in medical terms) the relevant chronology concerning this debate. This description does not highlight the 'leaky' nature of these dates. Instead, it provides a brief summary of the 'official' version of the '1995 pill scare'.

The five studies associated with the occurrence of this 'scare' purport to provide epidemiological evidence that the COCs containing the newer third generation progestogens, desogestrel and gestodene, are associated with an approximately two-fold greater risk of venous thromboembolism (VTE) than older formulations.[20] In October 1995, the United Kingdom Committee on Safety of Medicines made recommendations concerning the prescription of 3GOCs (Egermayer & Roke, 2000, p.49). The New Zealand Ministry of Health subsequently issued advice (including that 3GOCs only be prescribed as the first line/option) and created pamphlets for general practitioners to distribute to consumers. I have found different accounts regarding the rate of mortality which links the cause of VTE deaths to 3GOCs. This is perhaps, in part, because there is ongoing debate about causation. Published medical material states that in Aotearoa/New Zealand there have been nine deaths reported in women using 3GOCs since 1993 (Egermayer & Roke, 2000, p.49) and that there have been twenty VTE deaths, fifteen of which can be linked to use of 3GOCs (Egermayer & Roke, 2000, p.49). Following these deaths and the 'pill scare', the market share of third generation OCs in Aotearoa/New Zealand dropped dramatically from 76.8% in 1995 to 31.5% in 1999 (Egermayer & Roke, 2000, p.52). Prior to the 'scare', 3GOC products were "perceived to be safer and were therefore preferentially prescribed" (Egermayer & Roke, 2000, p.51).

The key results, which have subsequently been vigorously debated and criticised for confounding factors and bias, are considered to be the findings that there are relatively higher risks of VTE in users of OCs containing third generation progestogens, compared with non-users and those taking older formulations. Indeed, another point of contention is that even some of the researchers affiliated with the 1995 studies have seemingly revoked their conclusions. For instance, Spitzer (1997, p.2347) stated that "the relative risks of 3GOCs for VTE, even if real, are clinically unimportant and of no public health significance". I would argue that it

does not necessarily follow that because the clinical risk is "unimportant" that the issue is also of "no public health significance". On the contrary, given the high prevalence of OC use in Aotearoa/New Zealand, and other countries, these findings have serious implications for users, their families, their partners, health care services, health practitioners and drug companies.

Many health providers prefer to describe the 3GOC *controversy* as a *'pill scare'* because, like Spitzer, they do not see the clinical risk as statistically significant. The meaning of 'scare' here – while conveying some sense of fright – primarily implies that the worries many users (and some doctors) articulate are properly resolved only through medical peer review and via appeal to disembodied 'facts'. Notwithstanding this construction, it is my argument that the consumers I interviewed respond to this medical controversy by utilising not only 'facts' but also other strands of knowledges. Consequently, I prefer to refer to the 3GOC debate as a controversy. This term is capable of conveying a sense of these issues in a way that 'scare' is not. 'Controversy' is indicative of a dispute or disagreement in which there are strong alternative positions. Despite attempts by some medical professionals to diminish this 'scare' as what one doctor interviewed referred to as a "storm in a tea cup" (Luxi, interview 13/10/2000), the attention to meaning undertaken in this thesis reveals that there is, indeed, a controversy. For example, even the meaning of the word 'safe' in the context of OCs is contestable and 'slippery'. I think it is more appropriate, therefore, to conceptualise the 3GOC debate as a controversy rather than a 'scare'.

The mass media have played a big part in the 3GOC debate. While participants criticise the media's tendency for "sensationalism", they also acknowledge the ability of this medium to make a medical issue accessible. Divisions, conflicts and contestable meanings, once hidden, are more likely to surface in times of controversy, especially if the media function as a provider of information.[21] In her article on the controversy surrounding cholesterol in the mass media, Lupton (1994) isolates the media as a site for the discursive struggle over meanings, where a number of competing discourses are negotiated. Other social science literature on medical controversies similarly describe the central role played by the media in shaping discourses about issues such as risk (Powers, 1999; Darling-Wolf, 1997; Safer & Krager, 1992; Whiteman *et al*, 2000). In their account of the Halcion controversy, Gabe and Bury (1996) highlight the "contestability" (p.465) of knowledge. They emphasise the fracturing of a unitary stance on the controversy in favour of a "multidimensional character of events" (ibid). Many of the consumers I interviewed in this study respond to fractured knowledges on 3GOCs by adopting

the strategy of bricolage. My argument differs from Abraham's (1994) sole focus on the "interest-based bias" of medical knowledge in a controversy. A concern of Haraway's (1991, 1997) is also the 'interest-based' bias of scientific knowledge. The focus in this thesis remains the strategies and discursive practices utilised by a self-selected group of consumers and health providers who chose to discuss their responses to the 3GOC controversy.

In order to make sense of a controversy, people actively reconstitute their subjectivities and recraft the disparate collection of information that comprise the discursive 'toolboxes' (Lévi-Strauss, 1968, p.17) available to them. These knowledges are drawn from a multiplicity of sources and they are coded with diverse levels of prestige by different people. Armed with this information, consumers of medical technologies are able to begin the ongoing task of what Zena refers to as '(re)polishing' (interview 13/9/2000). The claim that knowledges and selves need continual attention is seen as opening not closing possibilities. Even medical professionals themselves, some of whom are in favour of settling 'facts', recognise uncertainty in this field. A very recent media article by Clausen (*The Press*, 13 November 2000, p.2), which discusses the most recent studies on 3GOCs and VTE, is a clear example of the difficulty of definitively settling knowledge. David Skegg highlights this problem when he says that it would be a "great pity" (*The Press*, 13 November 2000, p.2) if people thought that these studies were the "last word on the matter" (*The Press*, 13 November, p.2). This suggests that some medical professionals do not consider the reported studies to be conclusive evidence of the safety of 3GOCs.

Chapter Two continues my exploration of the 3GOC controversy through reflections on my methodology. In this chapter I discuss the ontological and epistemological positions that inform this thesis and how interview texts such as Zena's were generated. I argue that the stories which people tell about the 3GOC controversy (including my own) are drawn from established tropes and that they are not voiced in a vacuum, but set within a context. Just as some of the health professionals involved in the 3GOC controversy argue that the 'last word' on the debate has not been uttered, some of the consumers interviewed also suggest that this medical controversy is not what Zena (interview 13/9/2000) refers to as an 'isolated issue'. This medical debate has a context which is often embedded within personal biographies, contraceptive histories and future contraception concerns which require continual '(re)polishing'.

While the convention in theses is to begin with an outline of the theoretical agendas of the thesis, in this case, the methodology chapter appears first. This is because I want to resist the separation between theory and methodology. The meaning of theory is shaped by its interaction with 'grounded', or 'concrete' (Lévi-Strauss, 1968) knowledge and the production of this type of knowledge is informed by theory. Throughout this thesis, I attempt to introduce theory via the 'talk' of those who participated in this research. Chapters Three and Four develop the connection between abstract theory and 'concrete' experiences through an illustration of bricolage at work. Chapter Five develops bricolage in action by analysing the ways that some consumers constitute themselves as 'informed' once they have gathered and evaluated a collection of knowledges. In each of the chapters, the voices of consumers occupy prominent positions. In this respect I attempt to highlight the stories that as Patricia Grace (1988, p.28) puts it, are rarely "worded".

NOTES

[1] See appendix 4 for the interview schedules. Also see appendix 6 for information about how this study's participants were accessed and some biographical details.

[2] The etymology of 'bricolage' and the noun 'bricoleur' is French. Bricoleur literally means a 'jack-of-all-trades' or 'handyman' [sic]. Bricolage means to potter about, or do odd jobs. These terms entered social theory via Lévi-Strauss' (1968) comparison of 'savages', who utilise bricolage, with engineers. See Chapters Three and Four in which I discuss bricolage as a concept in action as it appears in some of the interview transcripts.

[3] See media appendices 8, 9, 10.

[4] See media appendices 8, 9, 10.

[5] See appendix 7 for these government handouts.

[6] See appendix 8 for 1999 media coverage of 3GOC controversy.

[7] Special Authority enables some consumers subsidised access to certain pharmaceuticals. It is available for all hormonal contraceptives, removing the manufacturer's surcharge, allowing the consumer to pay only the $3 dispensing fee. An application for Special Authority is usually made by a doctor on behalf of a consumer who cannot afford the cost of the pharmaceutical (Pharmac, 1996).

[8] See the research design appendix.

[9] Throughout this thesis I will use both knowledge, singular, and knowledges, plural. The former term will be used when I am discussing the Western tendency to uphold one true logocentric stance which is incapable of including alternative knowledges. By contrast, the latter term will be used to contest this Enlightenment impulse by revealing the inadequacies of one knowledge when some consumers are trying to make sense of a controversy. Contesting Enlightenment conceptions of knowledge, singular, is no easy feat. Indeed, this is demonstrated by the simple example provided by my computer. It insists on underlining knowledges in red every time I type it in order to highlight this word as an error. It seems that

even my computer dislikes the pluralism of knowledges embraced by bricolage and wants to reinstate knowledge!

[10] Please see Chapter Two for an explanation of my preference to speak of 'methodology' rather than 'method'. This chapter also gives specific details about the research process and methodology. It is reflexive in nature.

[11] See appendix 4 for the interview schedules.

[12] My theoretical approach to this thesis is discussed further in Chapter Three. Essentially, my focus is on the central metaphor of bricolage at work, with a focus on discursive practices and strategies invoked when faced with a medical controversy.

[14] See my methodology chapter where I am reflective about these theoretical anxieties and where I also comment on some email correspondence that discusses such concerns.

[15] For many of the OC users interviewed (and some 'alternative health providers), the current 3GOC controversy is embedded within a historical, present and (expected) future of analogous medical scandals. For instance, the public debates about the risks associated with the Copper 7, IUDs, depo-provera and abortion pill RU-486 were commonplace comparisons. For examples of these debates see: NZPA, 26 June 2000, 'Abortion Pill to be Tested', *The Press*, p.5.; Bunkle, P. 10 December 1990, 'the Claims Against the Copper 7', *Listener*, pp. 10-15.; Betts, M. 12 July 1999, 'Shot in the Dark', *NZWW*, pp.20-21.; Fleming, D. 22 September 1997, 'My IUD Nightmare', *NZWW*, pp.20-21. All these contentious debates deserve full treatments which are beyond the scope of this thesis.

During discussions about these medical controversies, participants often angrily questioned why there is no 'male contraceptive pill' so that men, too, can assume responsibilities. See for example the article entitled 'Next Stop...A Pill for Men?' (*New Zealand Women's Weekly*, 16 May 1988, p.52-53).

Finally, the Cartwright Report, and the "bloody old men" (Ellen, interview 7/9/2000) associated with "screwing up women's health care" is also mentioned on several occasions. Please see Chapter Five for a more complete discussion of the relationship between the Cartwright Report and the ongoing debate surrounding 3GOCs.

[16] Oral contraceptives were introduced to the Aotearoa/New Zealand market in 1961. Pill use increased dramatically throughout the 1960s and this country eventually became one of the highest users of OCs in the world (Doctor X, interview 14/9/2000).

[17] Estrogen and progestogen are the so-called 'artificial' steroid hormones that appear in OCs. Whereas oestrogen and progesterone are the hormones that occur 'naturally' within bodies.

[18] See my methodology chapter which provides a full description of my own personal 'story' of the 3GOC controversy.

[19] For interested readers, the articles published by Edwards, R. G. & Cohen, J. (eds) in the November/December 1999 issue of *Human Reproductive Update*, vol. 5., no. 6. provide excellent, detailed discussions of the medical position and evidence, clinical implications and new epidemiological studies in the area.

[20] The classification of OCs is as follows: each OC may be classified into one of three generations, depending on the type of progestogen contained. Each classification essentially correlates with the approximate time of market introduction (Doctor X). First generation products (although, according to Doctor X, this 'generation' of OC is not generally labelled as such) are usually taken to include those with high estrogen doses coupled with the older progestogen norethisterone. Second generation products contain low dose estrogen coupled with progestogen other than the third generation variety, usually levonorgestrel. Finally, third generation pills include the progestogens desogestrel and gestodene and norgestimate, in combination with a similar does of estrogen that is found in second generation formulations.

[21] My substantive chapters are interlaced with several more detailed examples from the mass media that pertain to the 3GOC controversy. See also appendices 8, 9, 10 for chronologies of

the media's treatment of the 3GOC debate, earlier contraceptive debates and other medical, especially contraceptive, controversies.

CHAPTER 2

STORYTELLING AND METHODOLOGIES

> There's a way the older people have of telling a story, a way where the beginning is not the beginning and the end is not the end. It starts from a centre and moves away from there in such widening circles that you don't know how you will finally arrive at the point of understanding, which itself becomes another core, a new centre. You can only trust these tellers as they start you on a blindfold journey with a handful of words which they have seemingly clutched from nowhere...Or sometimes there is a story that has no words at all, a story that has been lived by a whole generation but that has never been worded.
>
> (Grace, P. 1998, *Baby No-Eyes*, p. 28)

> Yes, I think that there is always a context. It's never an isolated issue...So you had a vested interest really. I think that's always the best place to start really. For starters, you've got a passion for it. People try to be 'objective' (*she laughs*). But you can't. It's better to just say where you're coming from. There's no point hiding or pretending. So I appreciate that. I mean you'll be objective with your findings by letting people say what they will and respecting that.
>
> (Zena, interview 13/9/2000)

Patricia Grace and Zena (interview 13/9/2000) have a firm grasp of the way that an issue is not "isolated" but embedded and situated within a context of "widening circles" which span the present, past and future. The recent 3GOC controversy is an occurrence that generates storytelling of this nature. Unlike Zena (interview 13/9/2000) and Grace, I arrived at this realisation late in the research process. As I conducted interviews, it initially unsettled me that many of the participants were not concentrating on discussing the 3GOC controversy itself. This was one of those occasions when my findings refused to "fit" (Becker, 1998, p.85) my initial research problem and questions. Instead of "ignoring" this "inconvenience" (ibid) I chose to grapple with the cases that did not "fit". I eventually came to conclusions similar to those articulated by Grace and Zena (interview 13/9/2000). While the 3GOC controversy is at the heart of this project, participants' responses to the debate are set within the "context" of their personal biographies. To put it another way, they create "new centre[s]" and "core[s]" through their storytelling about, not only the controversy itself, but also their contraceptive histories and 'life stories'.[1]

My exposure to and acknowledgement of the anxieties that occur during the research process is the primary focus of this chapter. Although the thrust of this thesis is to examine the discursive practices and narratives generated by the research participants, I would argue that it is also important for the researcher to "situate" (Haraway, 1991, p.135) her/himself. This is not to say that I want my own storytelling about my personal involvement in the 3GOC controversy to take centre

stage. Rather, the purpose of this chapter is to highlight that which underlies my research practices. Instead of "hiding" (as Zena, interview 13/9/2000, implied) my own epistemological and ontological orientations, I want to make my assumptions about knowledge production, for example, visible and subject to scrutiny.

This chapter, then, is not a discussion of my 'methods' of research but a 'methodology' chapter. Various theorists have clarified this distinction (Harding, 1987; Tolich & Davidson, 1999; Bloom, 1998). Essentially the difference lies in whether or not the researcher discloses and 'reflexively' (Tolich & Davidson, 1999, pp.35-39) critiques the assumptions underlying her/his research process. Whereas attention to 'method' involves a description of research techniques, procedures and practices; attention to 'methodology' involves making explicit the epistemological and ontological assumptions that a researcher brings to her/his project. 'Methodology' differs from 'method' because it is about addressing the philosophical assumptions that underpin research processes. As Zena (interview 13/9/2000) aptly argues, there is "no point hiding or pretending" that your 'method' is objective, devoid of any theoretical and personal underpinnings. Methodologies make what could be hidden, explicit and subject to scrutiny. The present chapter is concerned with investigating the researcher's own research process and practices.

My ontologies (theories about the world, such as questions about what 'exists') and epistemologies (ways of knowing or asserting what is 'real' in the world) are strongly influenced by feminist postmodernist and poststructuralist theorists (Haraway, 1991, 1997; Gavey, 1989). People who subscribe to postmodernism destabilise Enlightenment and humanist assumptions. They are not troubled to find that 'reality' cannot be transparently captured and consider meanings, even matters of 'fact', are inherently slippery and unstable (Jones, 1997; Davies, 1997; Haraway, 1991, 1997). Zena (interview 13/9/2000) would say that meanings are potentially open to '(re)polishing' and reinterpretation.

This approach did concern me intermittently during the research process. I imagined that the participants would feel betrayed because they had trusted me with their thoughts about a sensitive and personal topic and I would not necessarily convey what they "really meant". Indeed, during an informal discussion with one participant, Jacqueline, we exchanged thoughts about the interview material. After I described the way that I had analysed an excerpt from the transcript, she declared, with horror, that she could not "see" how I had "got that from what [she] said". Conflict over the meanings of any text is inevitable, according to poststructuralist theorists (Jones, 1997; Davies, 1997). With the 'death of the author' (Barthes, 1977),

there is an expectation that multiple readings are possible, despite authorial intentions. Therefore, while I speak throughout the thesis with an analytical voice, I do not assume authority over the transcripts. I accept that my readings are not the only possible ways to interpret the material. As Luxi – a doctor interviewed for this study (13/10/2000) - points out (through an analogy with viewer responses to television), "even if you and I see and hear the same thing, we won't necessarily interpret [the programme] in the same way because there are a hundred different ways that it could be interpreted". This is the type of philosophical orientation that is potentially disturbing to other research participants, but it is one with which I am sympathetic.

To be specific, from the outset of this project I have favoured an epistemological approach that does not presume that 'stories' about 'experience' unproblematically reflect a pre-existent 'reality'. Although my initial aim was to document participants' 'experiences' of the 3GOC controversy, I recognised that this aspiration could not be realised. This is because people's stories about what happened to them, why they took certain action or not, will not be accounts of what 'really' happened, but stories about what 'actually' [2] (Denning, 1994) occurred. Their storytelling constitutes layers of (re)workings, (re)memberings and, of course, '(re)polishing' (Zena, interview 13/9/2000). Haraway (1991, pp. 109-113) eloquently articulates this stance:

> Women do not find 'experience' ready to hand any more than they/we find 'nature' or the 'body' preformed, always innocent and waiting outside the violations of language and culture... 'Women's experience' does not pre-exist as a kind of prior resource, ready simply to be appropriated into one or another description... 'Experience', like 'consciousness', is an intentional construction, an artefact of the first importance. 'Experience' may also be re-constructed, re-membered, re-articulated.

A foundational approach, which treats 'experience' as incontrovertible evidence of claims, is rejected by Haraway. Meanings given to 'experiences' are inside not "outside the violations of language and culture". This means that any meaning that a person brings to an 'experience' depends on the discursive resources that are available and, thus, it is open to "re-construction". Ginny (interview 31/8/2000) illustrates this point in her interview when she concedes that what the controversy meant to her differed at various stages in her personal biography. For instance, in response to my question about what questions she asked her health provider about the risks associated with 3GOCs, she states that she "doesn't understand the risks in the same way now, looking back on it". And then towards the end of the interview, Ginny (interview 31/8/2000) "re-articulates" what she "probably thought about the risks at the time". Here, Ginny is engaging in precisely the sort of "construction" of 'experience' that Haraway refers to. There is no easy

access to a 'real' experience. Rather, the person's 'identity' is reconstituted, just as the 'experience' is (re)configured with each new narrative.

Just as Ginny (interview 31/8/2000) actively creates her selves and 'experience' through storytelling, I, too, (re)crafted my own 'experiences' of the 3GOC controversy with each new narrative. Throughout the practical phases of the research project I kept a journal. I also wrote a 'memo' (Tolich & Davidson, 1999, p.12) canvassing my personal story about my contraceptive history and, specifically, versions of my 'experience' during the 3GOC controversy. In both these documents I construct 'selves' through storytelling. Another way to express this is to say that my stories are exercises in what Somers (1994, p.613-614) calls 'ontological narrativity'. This notion suggests that selves are constructed through the telling of particular stories rather than 'expressed' or 'represented' in stories. There is a shift here from 'representational' (Somers, 1994, p.612) narratives to ontological storytelling that brings selves into existence. The difference is that the former entails the belief that it is possible to accurately represent an event or yourself through narratives; whereas, the latter stance holds that events and selves are *formed through* storytelling using established story genres. Subject to what narrative is privileged and deployed at a particular time, actors become certain people through the telling of the strategically chosen discourse.

Researchers are not immune to this 'ontological narrativity'. Through the journal, "free writing" (Tolich & Davidson, 1999, p.12) and interviews, I constituted my 'experience' and selves through the stories I told. For instance, in the journal I engaged in attempts to craft myself as a 'professional' sociological researcher. Given that my original training was in the humanities, the production of this particular self-story was particularly important. In addition, I also constructed my selves through storytelling about my 'experiences' of the 3GOC controversy. The versions I told about my 'experience' of the 3GOC debate depended strongly on the subjectivity privileged at the time.

I adopted different registers according to the person I was speaking to, often emphasising particular aspects of stories. For instance, the 'identity' I constructed for myself as a contraceptive consumer during my journal writing was one who was proactive and had a lot of energy for accessing information. And yet when I spoke to participants who expressed a desire to 'trust' health professionals rather than doing their own research, I sympathised with their strategy. I became acutely aware of my different selves speaking when I reflected on the stories that I had conveyed to Peter Kearns (Christchurch naturopath and Co-Director CCNM) during an interview

(26/8/2000) as opposed to the stories I told to Judith Sim, who is a Christchurch Natural Family Planning practitioner I interviewed (28/8/2000). While interviewing Peter Kearns, I asserted proudly that I discontinued the use of OCs in favour of something more "natural" and yet I critiqued the meanings of 'natural' and 'artificial' during the 'same' story I told to Judith Sim. Frank (1995) suggests that these reworked versions of a 'single' story are not uncommon. He explains that on one particular day he had "told a version of my illness story eight times" (pp.53-54) because people required different stories. My storytelling underwent similar changes and (re)polishing. The sequence of events was altered and (re)membered pieces of the story added and subtracted according to the self speaking.

The importance of being explicit about my 'ontological narrativity' became clear during the research process. I realised that a multiplicity of selves and experiential stories precludes 'sameness" (Haraway, 1997, p.57). This was highlighted through contrasts with my selves during the controversy and other consumers' selves. Actively creating myself as an 'assertive' consumer, I consulted various health providers after learning about the debate surrounding 3GOCs. Initially, a major focus of the project was to be the 'experiences' of consumers at their health care consultations during the controversy. My ethics application forms to both the University of Canterbury and Health Funding Authority indicate my preference that at least fifty per cent of participants would have consulted health providers. I soon realised that underpinning this desire was an assumption: namely, the presupposition that consumers do take action during controversies and that this action will entail consulting health providers.

On the contrary, some OC users I spoke to did not take any action and others, while they reacted to the debate, did not respond by consulting health providers. To illustrate, after speaking informally with an OC user, I note my "surprise" in my journal that she was unconcerned about the debate. Writing later in the journal, I recognise that I had unquestioningly "expected" other consumers to respond to the debate as I had. I conclude that such a "radical difference" in 'experiences' should indicate the importance of examining the assumptions I bring from my personal story to the research. Later in the research process, interview material similarly highlighted the minimal impact that the 3GOC debate had on some OC users. Zena (interview 13/9/2000), for example, mentions that her sister "couldn't have cared less about the debate" and she just "stayed on the pill, no worries at all". Zena's sister's response to the 3GOC controversy contrasts with mine. This illustrates the relational nature of selves. They are created through comparisons with other people's stories. These contrasts in 'experiences' alerted me

to the risks not only in failing to engage reflexively with my assumptions, but also the danger of expecting participants' stories to verify and confirm my own stories and selves.

It does not follow from these cautionary notes about 'experience' that I dispense with the idea totally. In fact, the researcher's personal biography is cited as the "best place to start" (Tolich & Davidson, 1999, p.13) research. So 'experience' (including the researcher's) remains pivotal. The shift lies in the emphasis. 'Experience', pursuant to some postmodernist and poststructuralist theorists (Jones, 1997; Davies, 1997; Kondo, 1990; Scott, 1992; Haraway, 1991), has been reconfigured as a discursive event. The accounts, narratives, or stories that participants give about their 'experiences' form the basis of analytical enquiries. Consequently, I wanted to find out what stories, knowledges and information proliferated during the 3GOC controversy. What stories were generated during the interviews I conducted with consumers and health providers? Why did differently positioned participants draw from certain stories rather than others? Although participants draw from conventional, established story tropes, how are these narratives uniquely deployed? What stories about selves are privileged? To this end, I asked questions about why participants paid particular attention to certain types of information sources rather than other knowledge. I also asked specific questions about their own personal biographies. In addition, I enquired about participants' memories of their 'experiences' during health care encounters.[3] The emphasis, then, clearly resides with an examination into discursively constructed 'experiences' rather than uncovering the 'real' experience.

My comfort with this discursive emphasis on the 'narrativity' of 'experience' was troubled as I conducted the interviews. I worried about reducing OC users' 'real' physical 'experiences' of side effects on the pill to poststructuralist signs and symbols. What I am referring to is the current centrality in much theoretical and empirical work about the material and discursive divide (Shilling, 1992; Shildrick, 1997; Frank, 1995; Williams & Bendelow, 1998; Oudshoorn, 1994; Usher, 1997; Barrett, 1992). Like many of the theorists involved in this debate, I became considerably irritated with what could be interpreted as poststructuralist reductionism. I was perplexed about how I could recognise OC users' physicality and simultaneously deconstruct their accounts of such 'experiences'. My anxiety centred around whether paying attention to discourse would deny the materiality of consumers' (often painful) side effects.

The interviews expeditiously quelled my fears. I was not negating material physiological side effects by focussing on the discursive. Few would deny that there are 'real' bodily activities occurring when an OC user 'experiences' a headache attributed to the pill. What my project was concerned with was exploring the meanings attached to such physiological phenomenon. Whereas doctors typically categorise headaches as 'minor' side effects from OCs, some consumers attach drastically different meanings to the 'experience' of this material occurrence. In an interview (7/9/2000) with Ellen, for instance, describes how her "pill headaches" become a 'major' problem for her when they made her a "crazy freak". This contrast in meanings for the same physical sign highlights the way that the material is mediated through the discursive, as Shildrick (1997) persuasively argues.

Discursive renditions enable people to explain and justify their actions and 'narrativity' can have material consequences. For example, subsequent to the discursive construction of the pill as risky, a material consequence followed: 2GOCs attracted a higher subsidy from Pharmac than 3GOCs (Egermayer & Roke, 2000; Edwards & Cohen, 2000). So, crafting stories during a controversy is not simply restricted to the discursive realm. As I discuss in Chapter Three, people have to actively pursue and seek out knowledges in order to compile their bricolage collections which provide meanings for them in a controversy. Bricoleurs demonstrate the materiality of building discourses by having to actively pick up elements from the discursive toolboxes 'at hand'.

In addition to destabilising 'experience' (Haraway, 1991; Klein, 1983; Mies, 1983; Stanley and Wise, 1983; Scott, 1992) some postmodernist theorists also subject the category 'women' to debate. In particular, writings by women from "marked" (Haraway, 1991) groups such as Maori, African American, and the 'third world', have upset the presumption that woman equals white, middle class and Western (Spivak, 1999; Awatere, 1984; Hooks, 1992). A generic 'woman' is not possible because women do not comprise a homogeneous group. It is now unacceptable to presume that just because "she bleeds [menstruates] like I do" (Emily, interview, 13/9/2000), that this biological connection will result in analogous 'experiences'. On the contrary, women's differences are emphasised because it is acknowledged that people's selves are crafted through the intersection of various social axes such as class, race, sexuality, religion and gender.

This unsettling of 'woman' had implications for my research. Rather than interviewing a statistically representative group of women and health providers, I chose to do in-depth interviews with a small number of women and health providers

identified via notices, advertisements and personal networks. However, I did want to try to elicit a range of responses. To aid this end, I placed a number of notices[4] at different health care centres throughout Christchurch. Specifically, in June and July 2000, I placed notices inviting participation in my study on the notice boards of the following health care organisations: The Health Alternatives for Women, Christchurch Family Planning, Christchurch School of Medicine, Canterbury College of Natural Medicine, Natural Family Planning, University of Canterbury Student Health, High Street Medical Centre. I also placed an advertisement inviting participation in this project in the Christchurch *Press*. The impetus behind my decision to utilise notices and advertisements as methods for accessing participants was twofold. First, the sensitive, personal and contentious nature of the topic suggested that it would be preferable to access people who were comfortable talking about the issues and who could make decisions about participation without feeling under direct pressure from the researcher. Secondly, I placed notices at a range of health care organisations in different locations throughout the city in order to maximise my chances of accessing differently positioned people who might draw from various discursive resources in their responses to a medical debate.

Despite comments that I had approached a "good range" (Peter Kearns, Co-Director and naturopath, Canterbury College of Natural Medicine, interview 26/8/2000) of health care organisations, it transpired that the consumers who responded to my notices were primarily "European" (as many described themselves in the demographic forms[5] I distributed), middle class, well educated and employed. However, I did interview a consumer who identified herself as Catholic and one who identified herself as Asian. These participants all suggested that the "taboo" (Heidi, interview 26/8/2000; Janet, interview 31/8/2000; Marion, interview 29/8/2000) nature of the topic of this thesis would very likely be a deterrent when other Asians or Catholics would have considered whether or not to participate. Reinforcing that this study can only be illustrative, Heidi (interview 26/8/2000) explains that she is an "atypical" Asian and, thus, "not representative". Similarly, Janet (interview 31/8/2000) was quick to point out on several occasions that her narratives "might not be what other Catholics would say". What Janet and Heidi suggest is that 'woman' is not associated with fixed meanings or categories. More importantly, though, they convey that even women within any particular grouping are different, dissimilar and "atypical".

This troubling of 'woman' contributed to my realisation that I occupied multiple social axes. In particular, as both a researcher and an OC user who participated in the 3GOC controversy, I was positioned both 'inside' and 'outside', as

Spivak (1993) has suggested. Possibilities and challenges emerged from having 'inside' and 'outside' selves. For example, several participants, such as one OC user, Janet (interview 31/8/2000), challenged my insider positioning. I initially wanted to have a question about whether the participant would like to know anything about my 'experiences' during the 3GOC debate at the start of the interview. Following my primary supervisor's advice, I placed this question at the end of the interview schedule. It transpired that this was indeed a good place to insert the question. This was suggested by Janet who explained that she was:

> happy to just be interviewed without too much of an exchange. I think that it is a good question to have in there because some people would feel like they have told you everything and want you to share something too. But I don't feel like that. This is a professional relationship. So I think that things need to stay on track. We should just stick to the questions. But I think that it is a nice question to put at the end so that people feel that they can ask you if they want to. It gives people the choice. But it's still good to have it at the end so that the whole thing doesn't get off target and become an exchange.

Interestingly, immediately following this remark, Janet proceeded to ask me about the personal impetus behind the research by wondering "how [I] came to do the project". Nonetheless, her central point was that although it is a "good question", the interview should not degenerate into an "exchange" because this compromises the "professional relationship" between researcher and participant in the context of an interview. Janet suggests that she favours an approach where professionalism is maintained by rigidly "stick[ing] to the questions" proposed by the 'expert' and not straying "off target" by engaging in unprofessional "exchanges". While she considers it an inappropriate question, she does accept that it offers other participants, who might want the researcher to "share", the "choice" and opportunity to do so. By placing the question at the end of the interview, it was possible to create a situation where alternatives to my own experiences, responses and actions could be facilitated.

I wanted to include this question at the conclusion of the interview in order to refrain from inducing participants into reworking their stories of the 3GOC controversy so that they matched mine. If I disclosed my stories first, some participants might have altered their stories under the impression that I would prefer to hear narratives that were consistent with my own. Consequently, I chose to place the question which invited "exchange" at the end. This allowed participants to tell their own stories without being influenced by my storytelling. And yet I did not expect that this approach would be entirely non-directive. As Middleton (1993, p.70) accurately writes, the "kinds of questions asked, the verbal and nonverbal reactions to responses...the physical setting itself" function by encouraging certain stories from participants. Despite the inevitable hints of researcher agreement or disagreement that can be gleaned from such signs, putting the "exchange" question

at the conclusion of the interview was successful inasmuch as it provided a "choice" and also avoided, albeit partially, researcher influence over participants' storytelling.

I also acknowledge that on the occasions when I did discuss my experiences of and responses to the 3GOC controversy with participants, this technique influenced the type of stories garnered. Generating a dialogue rather than the unilateral divulgence of their stories made some participants feel more at ease and comfortable discussing their own lives. For example, one participant, Jacqueline (interview 25/8/2000), asked me questions about what type of pill I had used, when I ceased usage, what health providers I consulted and why. She pointed out that she wanted to ask me these questions because she considered it "unfair if *we* have to tell *you* everything" (Jacqueline, her emphasis).

Jacqueline's emphasis on the pronouns 'we' and 'you' highlights the conventional distance between the researcher and her/his 'subjects'. I wanted to challenge the orthodoxy of the scientifically removed observer, while also being wary of allowing the insider position to generate 'talk' that confirmed my own responses to and experiences of the 3GOC controversy. My approach was to have the 'exchange' question at the end and if participants asked me questions during the interview, I would simply indicate that we could delay such conversations until the conclusion of the interview. If a participant was particularly frustrated with this response, I would answer her question(s) briefly and indicate that we could discuss the issue(s) further at the conclusion of the interview. I hoped that this technique would serve a dual purpose: it would both indicate to participants that I was comfortable sharing stories, but it also avoided (albeit not totally successfully, as Middleton's account suggests) participants changing their stories in order to 'match' my own. Since my own responses to the 3GOC controversy could be interpreted as 'bricolage', I wanted to resist privileging this position during the interviews in order to facilitate alternative stories. I did not want to do all the talking all of the time and I did not want to encourage stories that confirmed my own experiences, but I also did not want to alienate participants by refusing to share my stories.

At the conclusion of the interview (25/8/2000), Jacqueline conveyed the importance of sharing 'experiences' during the research process. She explained that it is "great for women to share their experiences of health and the pill" because "too often they don't get an opportunity to do this at the doctor's because he [sic] isn't interested in that". Jacqueline clearly expresses her satisfaction in a joint effort to generate stories about contraception and the 3GOC controversy. She also significantly points out that these types of stories are obscured by 'official' versions.

I anticipated that this storytelling might "never have been worded" (Grace, 1998, p.28) before in this capacity. Jacqueline's remark suggests that it is worthwhile documenting these narratives. And her comments indicate the importance of setting up a research atmosphere which garners such stories.

On one occasion, it was not even necessary for me to monitor or reduce my role in the research process. During the interview (31/8/2000) with Dr Rosemary Reid, for example, she read out the interview questions from her own copy of the document and then proceeded to provide answers completely unprompted by me. Rather than allocating the task of asking questions to the researcher (which is the conventional technique), I would argue that Dr Rosemary Reid engages in resistance by acting as both 'researched' and 'researcher'. In her article "Interviewing – An 'Unnatural' Situation?", Jane Ribbens (1989, p.561) analyses similar situations, what she calls 'subtle sabotages', where researchers have experienced shifts in power relations and interviewed in a hierarchical atmosphere. Ribbens conceptualises the interview as a 'social encounter' and explores the shifts in power and control between 'researcher' and 'researched' in this relationship. Ribbens argues that research interviews often involve power imbalances that stem from public domains and that these can have implications for "how people talk to each other and what they say to each other as a result" (p.579). Endowed with a 'public' medical authority, Dr Rosemary Reid does not dispense with this when in the supposedly 'private' research encounter.

At the time, I did find this slightly unsettling, even though I did not want to position myself as more powerful than the person I interviewed because researchers are frequently those without knowledge in research encounters. As the interview progressed I did interject with questions of my own, often ones which were not on the original list of questions.[6] The point remains, though, that this is but one example that illustrates the difficulties in assuming that the researcher and participant occupy the same "critical plane" (Harding, 1987, pp.180-181) as some feminist theorists, especially standpoint feminists, have advocated. As Cotterill (1992, p.599) points out, the balance, or imbalance, of power and control in a research encounter is not "fixed and may vary according to...the age and status of the women being interviewed...[and also] on the perceptions of the person being interviewed". At the beginning of the research, I anticipated that achieving equality in the research process needed to be sought after in terms of the researcher resisting elevating her/himself above the participants. Yet the interview with Dr Rosemary Reid (31/8/2000) suggests that the same "critical plane" is often a goal which cannot be aspired to because of the position(s) assumed by the participants.

My scepticism about the possibility of being able to produce an entirely equal research relationship is reinforced by the slippery meanings of 'feminist'. As a feminist researcher, I learnt that I could not presume that participants who identify themselves as feminists share the same understandings. This leads some theorists to propose that 'feminism' should be 'feminisms', plural, in order to resist the erroneous thinking that there is a homogeneous feminism (Harding, 1987, p.7). The tensions across meanings of 'feminism' are demonstrated in an excerpt from my journal. After my introductory visit with Cindy Carmichael at THAW, I collected one of their brochures. I wrote in my journal afterwards that this pamphlet and my discussion with Cindy revealed that THAW "has some 'essentialist' and/or 'older' strands/versions of feminism. In particular, there is a continual separation between the categories 'men' and 'women'. These categories do not seem to be contested at THAW as they are in say, postmodern feminism" (p.9). THAW's delineation between 'men' and 'women' does not sit easily with postmodern feminism which holds that feminism is not a stance dependent upon a person's gender.

So, unlike some feminist researchers, who define their type of research as being fundamentally concerned with women (Cook & Fonow, 1986, p.5; Stanley & Wise, 1983, p.196), my position follows other theorists who hold that men can make useful contributions to feminist projects (Harding, 1987, pp.11-12). In an interview (7/9/2000), Ellen enquired about whether my research would investigate "how males see the whole thing as well in terms of their experiences of being with partners on the pill during the scare". Although I had to answer this question in the negative, this thesis does explore the storytelling of some men who were involved in the controversy. These men were not OC users' partners, they were health providers. Despite my focus being on consumer narratives about the 3GOC controversy, I wanted to interview some differently positioned people in order to explore what storytelling is privileged by a variety of people within a controversy and why. I also wondered whether there would be any overlap between the subjectivities reinstated during the controversy and the sorts of narratives that different groups drew from in their storytelling. Indeed, I found that participants who are typically positioned as holding divergent views, often had overlapping narratives with the 'other' depending on the particular self that the person privileged at the time.[7]

My decision to include a variety of people who participated in the 3GOC controversy in the study meant that I sometimes interviewed health providers whose positions on this controversy were very different from my own. The health providers I interviewed were contacted in different ways. For example, Doctor X and Doctor

Rosemary Reid responded to the notices and interviews with Family Planning Association, Natural Family Planning and The Health Alternatives for Women were attained through phone, letter and personal negotiations. The interview with Canterbury College of Natural Medicine was the result of a letter and visit to the clinic. The midwife, Margaret Kyle, who I interviewed was contacted through a consumer, Ellen, who suggested that I interview her "midwife friend". Fewer than expected consumers interviewed for this study responded to the notices placed at various health centres around Christchurch. Of the eleven consumers interviewed, four responded to the notices, four were as a result of 'snowballing' (whereby their friend who was interviewed suggested that someone they knew be interviewed too) and three were contacted by representatives from health organisations on my behalf.[8]

Two contraceptive consumers contacted me, in response to notices placed at health care clinics, who were not interviewed. One consumer decided that she had not been on the pill for a sufficient length of time to make a valuable contribution to the project. The other consumer had used oral contraceptives but ceased usage well before the controversy began. She, too, felt that this would mean she would be unable to provide the study with suitable information. All the other consumers and health providers who contacted me through notices and advertisements were interviewed. Some participants referred me to other people who might be appropriate to interview, but three such opportunities were not followed up due to the limitations of the number of interviews I could conduct for a small research project.

It is worth emphasising here that I did not always agree with the consumers I interviewed. My point is that I made a conscious effort to take people's narratives seriously irrespective of whether my own views were dissimilar. On occasions, I recorded stories that were very different from my own. For instance, I had to emphasise my sociological self to one of the health provider participants who was concerned about whether the "medical evidence" would be accurately represented. I explained that, as a sociologist I was not interested in resolving the physiological debate surrounding thrombosis and 3GOCs, but that my concern was to explore the meanings, discursive strategies and storytelling which circulated during the controversy. After this incident, I wrote in my journal that my area of interest was not "whether or not something is true (i.e. how risky the pill is), but *where* people get their knowledge from and *who* it takes for them to be convinced/persuaded that something might be *true*?" Having isolated this as my focus, I also recognised that narratives from people who were not focussed on this aspect should also be taken seriously and the assumptions beneath their preferences probed. To this end, I have

started four of the six chapters in this thesis with a quotation from participants. Much empirical work makes its way into an analysis through quotations from 'experts'. However, I decided to start with participants' storytelling and work my way out to broader issues in order to ensure that participants' narratives are taken seriously.

The extent to which I "let people say what they would say and respected that" (Zena, interview 13/9/2000) was problematised once I started to privilege material that was of interest to my theoretical orientation. Once I started to look for evidence of bricolage, some material inevitably received more attention. Despite the differences and variances in the responses from the consumers interviewed, I have isolated several key features of bricolage and constructed health consumers as bricoleurs.

The result is what is referred to as "messy texts" (Marcus, 1994 cited in Denzin, 1997, pp. xvi-xvii). Although I did not arrive at the interviews with the notion of bricolage, I valorised this approach to the 3GOC controversy through the questions I asked participants. For example, I asked the contraceptive consumers in this study about what information they sought during the 3GOC controversy and why they chose particular types of information. I also asked questions about what type of action they took in response to the controversy. Finally, I asked whether they spoke to health providers and/or other people, such as friends, 'alternative' health practitioners, about the controversy.[9] I have sifted through the transcripts and privileged stories that illustrate the bricolage strategy. The 'mess' being referred to highlights the researcher/writer's involvement in the production of research material.

I, as the researcher/writer, became a "scribe" (Denzin, 1997, p.xvii) who "voices interpretations about the events recorded...and shapes the representations that are brought to the people studied". 'Messy' texts are grounded in the study of narratives and the stories people tell as they make sense of events like the 3GOC controversy. In other words, the narratives provided by this study's participants and the readings that I bring to these texts, are reflexive. What was noticed shifted and changed during the research process.

I respected participants' preferences for certain issues to the extent that I altered the initial focus of the thesis. When I began this research I envisaged that it would take the form of an analysis of consumer responses to the media's representation of the 3GOC controversy.[10] The notices I placed at health care

institutions invited people to participate in discussions concerning the "ongoing controversy in the mass media". Although I did ask questions about the media's construction of the debate (and some participants did utilise the media as a source of information), this aspect was not discussed extensively. The consistent response was that the media "sensationalised" the controversy. But most participants also pointed out that the media played an important role in the disclosure of the debate. For instance, Marion (interview 29/8/2000) states that it was "good that [the media] reported it because we might not have found out otherwise". Yet discussions about the controversy and the media rarely progressed or developed further.

What was volunteered without any prompting on my behalf was discussion concerning 'informed consent/choice' as it related the 3GOC controversy. It was an early goal in the project to ensure that those interviewed felt free to guide the conversation into areas that they considered important. In my research journal I pose these questions: "What do [participants] say unprompted? What is important for them to talk about?" (p.13). Despite my anticipations that the media would be a central issue and that "informed consent would probably be a significant, but peripheral, issue which is largely beyond the scope of the project" (journal, p.25), it transpired that the medico-legal issue was of pivotal importance to consumers I interviewed. Indeed, issues surrounding it are a major focus of Chapter Five.

It might reasonably be objected that 'informed consent/choice' emerged as a significant issue due to the self-selected group of people who participated in this research project. What I am suggesting is that the notices inviting participation attracted people who were primarily assertive as health consumers and had a lot of energy for accessing information about the controversy from a variety of sources and discussing the issues. The notices, in general, had quite a low response rate (only four of the eleven consumers interviewed were accessed through notices and they were potentially read by hundreds of women). While four participants were interviewed as a result of suggestions from their friends who had spoken to me during an earlier interview, the way that these people were accessed meant that interviews with more assertive health consumers were conducted. Since these people associated with the assertive health consumers I had already interviewed, it was likely that they, too, would be assertive as contraceptive consumers. Despite my attempts to place notices at a range of health care clinics around Christchurch, the final group of participants comprised of many consumers who were similar to me in terms of responses to the controversy. I have been able to construct many of these participants as bricoleurs as a consequence of the ways that these consumers were accessed.

Neither the notices nor the snowball technique succeeded in accessing participants who had 'survived' thrombosis attributed to 3GOCs, or Maori interviewees. Although a Christchurch marae was approached on several occasions, participation did not eventuate. The marae was approached using letters. Subsequently, there were several positive phone conversations with the nurse associated with the marae. I was concerned not to exclude tangata whenua from the study. As Tuhiwai Smith (1999) points out, even if the researcher's ethnicity is different, omission of indigenous people's voices based on this distinction is not the solution. In fact, a nurse on the marae indicated that potential participants might feel more comfortable talking to me because I identified as Jewish and, therefore, would not be considered Pakeha. She also suggested that there would be few people to talk to because oral contraception was not a popular contraceptive method for women associated with the marae. I eventually foreclosed the pursuit of Maori participants due to time pressures. More might have been done to facilitate participation from a wider range of participants given additional time and an extended study. These omissions from the sample highlight some of the limitations of my methodology.

One methodological asset was that I was vigorous about protecting the identities of participants. No long case studies of participants are included in the thesis. In a small city like Christchurch and a tiny country like Aotearoa/New Zealand it is too easy to identify participants and the priority was to provide participants with confidentiality. It was also vital to protect participants' identities because of the potentially contentious nature of the research topic. I often felt torn by divided loyalties to the differently positioned participants who all wanted their stories about the controversy adequately represented in the thesis, partly, because of the high profile that the debate received in the media.

A final note about the contents of my methodological practices concerns the way that I have incorporated and analysed participants' stories. I was initially anxious to ensure that all important aspects from participants' narratives would be included. I quickly realised that this is an impossible task. I have adopted Becker's (1998, pp.71-76) 'trick' exemplified by the "case of ethnomusicology". This 'trick' holds that the researcher's choices inevitably leave things out, but that this is acceptable provided s/he is reflexive about why such omissions were made which involves her/him questioning what can be said about what "we didn't see on the basis of what we did see" (p.75). For example, while this thesis focuses on a strategic response to a medical controversy that I refer to as 'bricolage', in Chapters Three

and Four, I recognise that this primary focus eschews alternative responses that participants might adopt in response to a medical debate. I only spoke to a limited number of people from a specific range of contexts. Many of the tertiary educated, young consumers I interviewed, but not all of them, deploy the 'bricolage' strategy. The extent to which this study's participants utilised tactics of gathering and combining information differs too.

This chapter's investigations into the assumptions underlying my research practices indicate that what I *saw* was influenced by the epistemological and ontological presuppositions I brought to the research questions. I conceded the importance of acknowledging what Zena (interview 13/9/2000) refers to as a "vested interest" in the study's subject matter. Some of the research questions had their origins in the biographical details of my own life. Consequently, the research process was often what Janet (interview 31/8/2000) called an "exchange" of contraceptive 'experiences'. This "exchange" and intermingling of narratives does not end with the conclusion of practical aspects of the research process. On the contrary, I co-construct the 'data' as I write my analyses of the interview transcripts. The co-creation, (re)creation and '(re)polishing' of different information sources pertaining to OCs, through a strategy that I interpret as 'bricolage', is the topic of the next chapter.

NOTES

[1] My use of 'life story' follows the definition utilised by Du Plessis, Higgins & Mortlock (2000, p.5). They interpret 'life story' as a "personal story about some aspect of a narrator's life, not a comprehensive account of 'a life'" (ibid). While this study's participants' 'life stories' frequently cover past, present and future aspects of their biographies, they are, nonetheless, narratives about their contraceptive, and sometimes medical, histories, rather than accounts of their lives in general.

[2] Denning (1994) uses the terms 'really' and 'actually' in order to delineate between realism and acting, performance or construction. He argues that what really happened, or the so-called 'real' story, can never be discovered because we can only ever know what actually occurred, or a version of 'reality'. He relates this notion to Clifford Geertz's concept 'thick description', whereby the competing layers of representation are described thickly. Whereas the realist mode of examination claims to scrape away multiple layers and reach the 'truth' left at the bottom, Denning and Geertz argue that the illusion of realism needs to be negated by paying attention to innumerable cultural constructions and the performance of what 'actually' happened.

[3] See appendix 4 for the interview schedules which include the specific questions that I asked participants.

[4] See appendices 1, 2, 3 for the notice, consent form and information sheets placed at health organisations around Christchurch.

[5] See appendix 6 for the demographic information.

[6] See appendix 4 for the question schedules. These documents traverse the themes to be pursued but they were not used as question sheets. In other words, the interviews did not follow a linear path from question one to the final question. Nor did the interview 'questions' preclude transitions to other topics prompted by the participants. I adopted a semi-structured approach which permitted such transgressions. The aim was to allow the participants to have more control over the structure and direction of the interaction than would otherwise be the case. The appendix includes the schedules used for OC users, health providers and the medical law specialist. I used slightly different schedules for the various health organisations interviewed. While the core questions and themes remained the same across all health providers, I have included the different questions that were asked of specific health organisations.

[7] Refer to Chapter Four where I discuss this finding in more detail.

[8] Refer to appendix 5 for further details about this study's research design, including which participants were accessed through notices as opposed to those who were accessed through 'snowballing', or through health professionals.

[9] See appendix 4 for the interview schedules.

[10] See appendix 8 for information pertaining to the media coverage of the 3GOC controversy.

CHAPTER 3

BRICOLAGE: MAKING ABSTRACT THEORY CONCRETE

> That sort of language [academic and medical] doesn't get you anywhere. There is no action, no politics, so what's the point?
>
> (Cindy Carmichael, THAW, interview 24/8/2000)

The potential apolitical and inaccessible features of 'academic language' are highlighted by Cindy Carmichael's (interview 24/8/2000) comment above. Cindy is commenting critically on difficult language in general, but similar criticisms have been directed at postmodernism and poststructuralism (Hall, 1990; Bloom, 1987; Harding, 1983; Graham, 1995; Suleri, 1989; Pihama, 1988). One particular concern is that these theorists often make simple points in an elaborate and obscure way. This critique troubled me somewhat because I wanted my research to be accessible to people from a variety of backgrounds. It bothered me that a potential corollary of utilising theoretical frameworks, which have been criticised for their inaccessible discourses, would be that I would fail to convey my argument to people who were unfamiliar with these ideas. My worry was similar to Cindy's. I, too, wondered "what [would be] the point" of adopting aspects of postmodernist analysis if only a small group would be able to understand my arguments.

In addition to the inaccessibility of postmodernist and poststructuralist writings, I was also concerned about other critical formulations, in which these two terms frequently appear, such as: 'if discourse is all there is....,' or 'if everything is a text...,' or 'if the subject is dead...,' or 'if real bodies do not exist....' (Butler, 1992, p.3). And opponents of postmodern orientations (MacKinnon, 2000; Waters, 1996; Klein, 1996; Thompson, 1996; Spretnak, 1996) also voice fears similar to Cindy's such as whether this theoretical position negates "politics" and "action". Similarly, Actor Network theorists have had to defend themselves against charges that their arguments betray the existence of 'reality'. In his book *Pandora's Hope* (1999, p.1), for example, Latour provides answers to the question posed by his friend about whether he "believe[s] in reality". All these fearful articulations constitute the main reasons why I questioned whether adopting a postmodernist and poststructuralist approach was problematic. Butler (1992, p.4) Singer (1992, p.460) and Flax (1992, p.475), albeit in varying ways, respond to the arguments that some postmodernist and poststructuralist ideas are apolitical.

The primary purpose of this chapter is to introduce and defend my use of the following ideas and concepts that are central to this thesis: subjectivity ('body-self'),

'bricolage/bricoleur', 'blackboxing' and 'whiteboxing'. I draw on several theoretical concepts from Actor Network Theory including 'blackboxing' and 'immutable mobile'. I invoke a term which I have created called 'whiteboxing'. This is an extension of what is called 'white box testing' by engineers. 'Bricolage/bricoleur', 'blackboxing' and 'whiteboxing' are the central theoretical ideas running throughout this chapter; whereas, 'actor', 'subjectivities' and 'immutable mobile' are drawn upon in order to discuss these central theoretical concepts more fully.

The 'theoretical' ideas[1] discussed in this chapter are presented in a concrete rather than an abstract manner. Although it is customary to demarcate theory from interview material, since the central theoretical concept in this thesis (bricolage) is one which is *practised* by people, it follows that this theoretical chapter utilises concrete extracts from this study's interviews in order to illustrate bricolage at work. Furthermore, following Foucault (1988, p.68), I would argue that the theoretical orientation that I am utilising "is practice". Many of the OC users I interviewed exemplify the *practice* of several of these theoretical notions. Specifically, in this chapter I interpret these 'actors" responses to the 3GOC controversy as 'bricolage'. Bricolage is 'grounded' in everyday activities rather than being relegated to the realms of inaccessible abstraction. Given that the theoretical approach in this chapter involves illustration by way of practice, I intend to analyse the key theoretical concepts alongside some substantiating examples from the interview transcripts.[2]

Such a pragmatic approach to a theory chapter is necessary because one of the primary aims of my study is to explore how a selection of people – but especially the OC users I interviewed - respond to the 3GOC controversy. My interpretation of the interview transcripts is that some consumers decide what action to take during the 3GOC controversy by invoking the practice of combining a multiplicity of forms of knowledge. I refer to this conceptual and practical process as 'bricolage'. It is necessary, therefore, to show bricolage in action. It is important to emphasise that I will show bricolage at work because I have read these contraceptive consumers' responses, reactions and 'storytelling' as 'bricolage'. But this does not mean that I am suggesting that 'bricolage' is the only possible way to respond to the 3GOC controversy. 'Bricolage' is *one* valuable aspect that I have selected from the interview transcripts because it is an especially prevalent method used by many of the OC users who participated in this project. They practise bricolage as they relate to a particular contraceptive technology and the controversy surrounding it.

The way that I use 'bricolage' and 'bricoleur' throughout this chapter and the thesis borrows from and develops its usage in social theory (Hess, 1997; Lévi-Strauss, 1968; Katovich, 1995; Weinstein & Weinstein, 1991; Weinstein, 1991; Preston, 1996; Turkle & Papert, 1990). The etymology of both concepts is French. The conventional definition of a bricoleur is someone who is a "handyman" [sic] or "jack-of-all-trades" [sic] (Hess, 1997, p. 139). This term entered social theory in Lévi-Strauss' major work on the 'primitive' mind (1968), but it has subsequently been embraced by qualitative researchers who promote bricolage as a legitimate method of inquiry (Denzin & Lincoln, 1994, pp. 2-3). In addition, researchers have interpreted other theorists as bricoleurs (Katovich, 1995; Weinstein & Weinstein, 1991) and the transcripts of interviewees have also been interpreted as "narrative construction [which] forms a bricolage from their babble of discourse" (Preston, 1996). Bricolage is also likened to "epistemological pluralism" and advocated as a valid approach to knowledge (Turkle & Papert, 1990). Of course this proliferation of work on bricolage has not escaped criticism from those who contend that the practice of theoretical bricolage undermines analytical work and that, thus, the metaphor of 'boatbuilding' is preferable (Hammersley, 1999). In order to follow my use of bricolage in this study, it is necessary to first explore the various elements of bricolage – tracing the connections and differences as they appear in social theory and in my writing - and then provide examples of bricolage in action. Given the inherent composition of bricolage - it is slippery, messy and practical - it is sometimes unavoidable that theory and practice will blend. This chapter illustrates bricolage by applying it to extracts from this study's interview material.

Bricolage is principally one way to make sense of the world. In *The Savage Mind* (1968), Lévi-Strauss contrasts the sense-making approaches of the bricoleur 'savage' with the engineer. Whereas 'primitive' people respond to the world around them by a process that Lévi-Strauss refers to as the 'science of the concrete' (1968, p. 16), the engineer makes sense of the world by utilising 'abstract' logic. Bricoleurs perform odd jobs using a limited number of tools which they carry with them. When faced with a task, they simply turn to their toolbox and adapt one to the situation. The bricoleur engages in practical problem solving, but, unlike the engineer who has the capacity to create knowledge, no new knowledge is created by the bricoleur. Instead, pre-existing tools and/or knowledges are reconstructed, reworked, and '(re)polished' (Zena, interview 13/9/2000). In the words of Lévi-Strauss, the bricoleur is:

> adept at performing a large number of tasks; but unlike the engineer, he [sic] does not subordinate each of them to the availability of raw materials and tools conceived and procured for the purpose of the project. His universe of instruments is *closed* and the rules of his game are to always *make do with 'whatever is at hand'*, that is to say with a set of tools and materials which is always finite and is also heterogeneous because what it contains *bears no relation to the current project, or indeed to any*

> *particular project*, but is the contingent result of all the occasions there have been to renew or enrich the stock or to maintain it with the remains of previous constructions or destructions. (1968, p. 17, my emphasis)

While I concede that the bricoleur will primarily "make do with whatever is at hand", Lévi-Strauss' articulation does not adequately illustrate the difficulties that bricolage can present during the 3GOC medical controversy. To be sure, the OC users interviewed collect information which has been "transmitted in advance" (Lévi-Strauss, 1968, p. 20) and they build bricolage from the "remains and debris of events" (ibid, p. 22), but accessing information is often a considerable challenge. The 3GOC controversy began internationally in 1995 but it did not circulate in the 'public' domain until years later. One reason for this delay is that the medical profession is often reluctant to allow information to "get out to the public" before it has been "peer reviewed" and "scientifically appraised" (interview 31/8/2000 with Rosemary Reid, medical specialist). The question, however, remains: how easy is it for contraceptive consumers to get access to information which is supposed to be readily 'at hand'?

Many of the consumers interviewed spoke about the problems that they encountered trying to access information about the controversy. Despite their reservations regarding the "sensationalism" (Jacqueline, interview 25/8/2000) and "inaccuracy" (Heidi, interview 26/8/2000) of the media, some OC users 'made do' with this information while they sought out other sources. My point is that, although consumers did utilise the information 'at hand' (such as media, talking to friends, family, partners, embodied experiences, personal contraceptive biographies), they also proactively sought out other sources of information because of the inadequacy of the 'tools' readily available. This is not to say that the information at hand is not valid. It is simply considered that this, alone, is not sufficient. It might be argued that the information that is collected by bricoleurs still constitutes information that is 'at hand' because it does not involve the creation of new knowledge. My purpose is not to argue about this point. Rather, I am suggesting that *accessing* even the knowledge which is supposedly 'at hand' is not a straightforward task. Ellen (interview 7/9/2000) has this to say about access to information about the 3GOC controversy:

> I couldn't believe it when I discovered that this drama had been raging for years and we didn't have any idea! I hate it how the medics keep these things to themselves. What, are we just meant to be content with what the media says or whatever? I had to go out and ferret around for anything – medical stuff I mean - that I could get myself. This sort of stuff doesn't just fall into your lap you know! Even talking to friends about it is sometimes an effort. Shouldn't it be the doctors' responsibility to be sending *us* information in the mail? I mean they're playing with *our* lives here! I mean I don't think that we should do nothing, but come on!

Ellen (interview 7/9/2000) is perturbed that she has to 'make do' with the "remains and debris" of a controversy that has "been raging for years" unbeknown to her, or many other consumers for that matter. Ellen is also clearly both perplexed and angry that the medical profession fails to ensure that important information pertaining to 3GOCs is readily 'at hand'. The difficulties that she describes regarding access to information indicate that the task of the bricoleur is not necessarily as trouble-free as one might imagine from Lévi-Strauss' description. As Ellen indignantly puts it, the bricoleur's potential toolbox does not "just fall into your lap". Ellen's discourse illustrates the connections and differences between the way that I use bricolage and bricoleur as opposed to the way that Lévi-Strauss defines these notions. Granted, the result of a bricoleur's efforts to access disparate bits and pieces is bricolage: a reconstruction of "heterogeneous objects" (Lévi-Strauss, 1968, p. 17). To "make do with whatever is at hand", however, is not a simple activity. What should arguably already be 'at hand' often has to be actively sought out. For example, Ellen (interview 7/9/2000) has to "ferret around" for information because she is not "content" to only "make do" with the sources that are 'at hand', provided by the media in this case.

Given that accessing information often requires effort, it is not surprising that the bricoleur is often placed in a position where s/he has to 'make do' with a 'stock' of information that frequently "bears no relation to the current project, or indeed to any particular project" (Lévi-Strauss, 1968, p.17). The individual consumer does not generate the latest contraceptive technologies, nor create the newest knowledge pertaining to such methods. She is, therefore, constituted in the position of the bricoleur. But while Lévi-Strauss assumes that bricoleurs are competent actors with a full toolboxes, health consumers often struggle to assemble their tools. Zena (interview 13/9/2000) certainly draws from materials collected from "old" and "new" experiences and sources, which are unlikely to have been connected with the 3GOC controversy specifically. Similarly, Emily (interview 13/9/2000) appears to 'make do' with an eclectic 'stock' of knowledges which she has collected over time and which are often only loosely related to the current medical controversy. Why do some of the consumers in this study feel that it is necessary to adopt this bricolage approach? Emily explains the impetus behind her regular additions to her toolbox:

> I read a lot. I have researched quite a lot over the years too. I have a good women's health book. I have magazine articles and I can get to university easily so I can also find whatever I want from there too. Some of my friends even have scrapbooks filled with mag articles on such and such an issue, nearly anything that might be helpful at some stage basically. I think we all just think that it might be useful one day and that probably the people who should supply the info won't *(she laughs)*. So I don't talk to GPs much anymore. When anything comes up, like problems with the pill, then I go back and have a look at these things. I really think that from my experience, doctors haven't been that helpful. In retrospect, that second doctor who I went to

> about my painful periods and who told me that I should go on the pill, that was really dodgy of her. I think that she should have been able to tell me a lot more things. Like, maybe if you cut out caffeine, which I have done, and completely regulated my painful periods by some simple changes to my diet and exercise routine. So it's just things like that which a doctor should know about and tell to clients. I didn't want to go back on the pill again because I noticed when I went off it the first time I was a lot happier. Sure it could have been other factors like moving to Christchurch. But I don't think so because then I remembered another earlier occasion which wasn't to do with the pill but it was that contraception injection which also affected me badly and so I think it's just these hormonal chemicals in general that don't sit well with me. Basically you have to put what the figures say in the context of your own body's responses to the treatment. I couldn't simply read the statistics as they appear. That's why those information leaflets you asked me about aren't enough by themselves. You've got to read them with other stuff.

This extract from Emily's (interview 13/9/2000) storytelling is lengthy but necessarily so. The toolbox of a bricoleur is customarily comprised of bits and pieces and odds and ends which sometimes "bear no relation to the current project", often because they are selected from personal biographies. The bricoleur links materials and information in the present to specific knowledges accomplished in the past and anticipated in the future. In order to solve "problems" raised by the 3GOC controversy, Emily "goes back and has a look at these things" which she has stockpiled "over the years". This accumulation of material involves reference to her personal contraceptive history, previous medical experiences generally, references from books, magazines and similar information from friends' "scrapbooks".

The scrapbook is arguably a quintessential manifestation of the activity of bricolage. Without "any particular project" in mind, Emily's friends simply assemble "nearly anything that might be helpful at some stage". The contents of such a scrapbook are "second hand" (Lévi-Strauss, 1968, p. 22) because they are not created by the bricoleurs themselves, but they are collected and retained on the "principle that they may always come in handy" (Lévi-Strauss, 1968, p. 18). They are deemed to be potentially "helpful" in the future. A controversy is almost anticipated or expected by these bricoleurs. Note, for instance, that Emily uses "when" not "if" as she speaks of future medical debates that might arise.

Certainly what is expected by Emily (interview 13/9/2000), and presumably some of her friends with scrapbooks, is any one of three scenarios including: that a medical professional will not disclose information, or that s/he will fail to disclose enough information, or that the information will be too abstract. The possibility of any combination of this sequence of events occurring provides an explanation for the phenomenon of scrapbooks and the activity of bricolage in general, which draw from material that is seemingly irrelevant to "any particular project". Reminiscent of Ellen's indignant comment that she "hate[s] it how the medics keep these things to themselves", Ellen also complains that "probably the people who should supply the

info won't". It is evident from these two observations that there is some scepticism about whether the people who have easy access to important information about medical matters will even disclose such material. In Chapter Five, I explore this concern through a discussion of the concept of 'informed consent'. My purpose in this chapter is to point out that these contraceptive consumers, who I argue are behaving like bricoleurs, adopt the activity of bricolage because of their reservations about access to information, materials and certain types of (medical) toolboxes. One way to respond to this predicament is to gather "nearly anything" over an extended period of time and create a "useful" file of such data in the form of a scrapbook, for example.

An additional concern raised by some consumers in this study is that doctors regularly fail to provide sufficient information, or certain types of knowledge. The complexities of this issue are also traversed in the chapter on 'informed consent'. For the moment, I want to address the matter of inadequate information in the context of bricolage. To return to a question posed earlier: why is it that these consumers feel they need to adopt bricolage? It is my contention that some contraceptive users experience difficulties accessing certain types of information and, as a consequence, they bolster their toolboxes almost in anticipation of the need to solve problems or extend their knowledge. Since one particular solution (for example, consulting a health professional) to the problem is deemed inadequate, it becomes necessary to seek out alternatives. As Emily (interview 13/9/2000) grumbles, it is because the doctor "should have been able to tell [her] a lot more things", but failed to do so that she ends up in a position of having to get the additional information, such as "cutting out caffeine...[and] changes to diet and exercise", via alternative avenues.

Due to her difficulties in accessing information and her experience that the medical advice provided is usually not "helpful", Emily (interview 13/9/2000) does not "talk to GPs much anymore". Eight of the eleven health consumers who participated in this study also share Emily's sentiments. This is not to say that these consumers interviewed never consult health professionals, but that they are sceptical about the advice they receive. For example, Jacqueline (interview 25/8/2000) feels that the medical profession "hush up" important health issues, and consequently women are "less informed" and have to "look it up [them]selves in textbooks". Clearly, then, accessing information supposedly 'at hand' can be an arduous task.

One method of attaining knowledges is to approach health organisations that are specifically set up to provide consumers with an assortment of information on a variety of health topics. One such Christchurch organisation is The Health Alternatives for Women (THAW). Indeed, at various stages in her narrative, Emily says that she "visits THAW all the time about health things". Her positive comments about THAW are not restricted to her personal opinion as she points out that "a hell of a lot of women use their service" and that she is continually "amazed" when perusing their "books at how many women visit them each year". Emily explains that she thinks THAW is popular because of their approach to health. She says that they "provide all sorts of info from different perspectives on anything you care to think about". Likewise, Ginny (interview 31/8/2000) also explains that when she "doesn't get enough information from doctors" she consults "women's resource centres...[and] women's health groups in Wellington" and, later, when she relocates to Christchurch, she "discovers THAW". Like Emily, Ginny also prefers these organisations because of the "range of information that they provide".

Cindy, a nurse associated with THAW whom I interviewed (24/8/2000), does not use the word 'bricolage', yet her comments about THAW's approach to health are suggestive of this technique. Cindy describes THAW's "philosophy" in the following way:

> We don't tell women what to do, we provide them with information on lots of people's opinions and then it's up to them to take what they want, follow that up and reach their own conclusions...Our information is half conventional, half alternative...We cover the whole field...So our approach is very broad...We sort of try to get the positive and negative sides of any issue, like the problems with the pill, and then people can take what they want. If you just have a look at all those folders there *(she points to rows of files which line the walls of the room).* Under each heading we put a hodge podge of info from all sorts of places. You can see that we have so much information and that we add to it constantly, almost every day in fact.

Cindy reinforces Emily's (interview 13/9/2000) and Ginny's (interview 31/8/2000) statements about THAW. In particular, the emphasis is on THAW's diverse "treasury" (Lévi-Strauss, 1968, p. 18) of "heterogeneous" (Lévi-Strauss, 1968, p. 18) information. The materials in THAW's office constitute an exercise of bricolage. Cindy describes the materials available to consumers as a "hodge podge" of "information on lots of people's opinions", which includes sources from "half conventional, half alternative" perspectives, both "positive and negative". THAW's unique ability is to ensure that they hold a "collection of oddments left over from human endeavours" (Lévi-Strauss, 1968, p.19) with which the health consumer as bricoleur engages and, hopefully, uses to make decisions about her own health care.

THAW's assemblage is necessarily "limited" (Lévi-Strauss, 1968, p.19) because they do not create the knowledge themselves but collect the "left over[s]"

from other health, feminist and government organisations. Once accessed, THAW then proceeds to "build up structured sets" of knowledges. This is illustrated by the folders which Cindy proudly points out. These "structural patterns" (Lévi-Strauss, 1968, p.33) are created by organising information into folders under the appropriate "heading". One of the tasks of a THAW employee is to "add to" these folders "constantly, almost every day". Cindy's words echo Lévi-Strauss' description of the "ordering and re-ordering" (1968, p.22) that a bricoleur engages in.

The purpose of this continual reworking or '(re)polishing' of the "same materials" (Lévi-Strauss, 1968, p.21) is the "search to find [the materials] a meaning" (Lévi-Strauss, 1968, p.22). Although the THAW office is like a bricoleur's creation, the people who work for this organisation do not complete the bricoleur's task of affixing 'meaning' to the assortment of information. This is because THAW avoids "tell[ing] women what to do" and, instead, encourages their clients to complete the job like that of a bricoleur by urging "them to take what they want, follow that up and reach their own conclusions". In other words, there is what could be likened to teamwork bricolage in operation here. THAW is responsible for the collection and ordering, reordering process, but their clients are obliged to do the additional reconstruction of the toolboxes and the final sense-making and problem solving components that a typical bricoleur addresses. Peter Kearns, a Christchurch naturopath and Co-Director of Canterbury College of Natural Medicine who was interviewed for this study (interview 26/8/2000), comments positively on THAW as a resource for health consumers when he says that "THAW does a good job with access to information...they are very effective in this regard". It is my contention that access to a diversity of information, but especially medical data, is often tricky. 'Conventional' medical knowledge rarely "falls in your lap" (Emily, interview 13/9/2000) or appears magically 'at hand', so a collective bricolage effort becomes necessary. Bricoleurs can work together to solve problems and this is just the sort of atmosphere that is generated by THAW. THAW has created what could be called a bricoleur friendly environment by providing easy access to a set of tools that enable health consumers to engage in an activity similar to bricolage. This type of approach to health matters is clearly appreciated by health consumers such as Emily (interview 13/9/2000) and Ginny (interview 31/8/2000).

A clarification is necessary at this point in the discussion. The type of bricolage which I have been traversing and that some of the contraceptive users in this study practise, is a specific variety of "mythical thought" (Lévi-Strauss, 1968, p.17) that Lévi-Strauss refers to as "intellectual bricolage" (1968, p.17). That is, a number of health consumers I interviewed select from a repertoire of extensive, but

nonetheless limited information at their disposal. The operative words here are 'intellectual' and 'information' because as Weinstein and Weinstein (1991, p.162) note, the intellectual bricoleur "does not do hand work with tools and materials, but brain work with signifiers and significations" (1991, p.162). Weinstein and Weinstein's use of 'signifier and signification' refers to a conceptualisation of language as a sign system. A sign is composed of a signifier and a signified (Saussure, 1966). The signifier is the material aspect of the sign; whereas the signified is the mental concept (Saussure, 1966). The relationship between the signifier and the signified is 'arbitrary' (Saussure, 1966) and yet the two together create signs which generate significations (meanings). Ferdinand de Saussure (1966) is an important theorist who explored language in these terms, arguing that meanings lie in relations of difference. For instance, a "safe" 3GOC acquires meaning only in its contrasting relation to being "dangerous".[3]

In other words, bricolage is not restricted to practical, everyday arenas, but is also able to operate within sign systems. Bricolage can be either/or, *or* both/and *intellectual* and practical. I would argue that many of the consumers in this study are intellectual bricoleurs, but that the way that they collect their information can be a practical, everyday activity (often an arduous one!) and that their decision making involves transforming the 'abstract' (intellectual) into the 'concrete' through examination of *embodied signs*. I will come to these elements later in the discussion. At present, I want to highlight that, although bricolage is not limited to intellectual manipulations, the particular variety that is exemplified by the consumers' storytelling in this study does primarily fall into the 'intellectual' category. To illustrate this point, many of the health providers and consumers in this study engage with meanings and sign systems that circulate before and during the 3GOC controversy. The consumers interviewed deploy a fixed stock of signifiers, including the forms that the medical controversy takes. They do not develop a special technical language to deal with the debate. Rather, they construct meanings from the bricolage of tools and materials (often sign systems) which are 'at hand'.

Bricolage is a term that comes from a structuralist theorist: Lévi-Strauss. However, in their article 'Postmodernizing (Macro)Sociology', Weinstein and Weinstein (1993) argue that bricolage can be conceptualised as a postmodern concept. They draw analogies between bricolage, 'discursive formation' and 'deconstruction', specifically because these three concepts stress "nonsystematic order" (p.224). They argue convincingly that there are "postmodernist elements to Lévi-Strauss's structuralism" (1993, p.226). Weinstein and Weinstein reach the conclusion that Lévi-Strauss "mutes his own rationalist search for deep structures

and emphasises bricolage as the form of cultural totality" (p.227). It is this postmodern flavour of bricolage that I contend provides most of this study's OC users with the ability to make sense of the 3GOC controversy. Since these consumers are working between and within competing and overlapping paradigms, the postmodern nature of bricolage assists them in reaching decisions about how to handle the controversy.

In general, dismantling foundations, disrupting hierarchies, unsettling the "modernist settlement" (Latour, 1999, p.14) and questioning the modernist master narratives that seek to oppress 'others', are some of the primary aims in most postmodernist projects. A Derridean (1976, 1997) deconstruction, for example, seeks to subvert the hierarchy of sign systems and to render them less authoritative. This allows marginal and excluded signifiers and subjectivities to gain presence. Anti-postmodernist protests (MacKinnon, 2000; Waters, 1996; Klein, 1996; Thompson, 1996; Spretnak, 1996) enter the arena at this point with claims that such deconstructions are actually destructions since they censure terms and render them nonexistent. However, as Butler (1992, p.16) persuasively reminds readers, this type of destabilisation manages to "release the term into a future of multiple significations, to emancipate it from the maternal and racialist ontologies to which it has been restricted and to give it play as a site where unanticipated meanings might come to bear". In liberating categories from fixed referents, new possibilities emerge and the potential for 'repolishing' becomes conceivable.

In order to explain why it is that bricolage can be conceptualised as a postmodern notion, it is helpful to compare bricolage with 'blackboxing' (Latour, 1999, p.304). Such a comparison does not set up bricolage and 'blackboxing' as a binary opposition since components of bricolage are more often than not blackboxes. But for the purposes of the present discussion the emphasis will be on contrasting these two notions rather than making connections.

'Blackboxing' has been used by sociologists of science to refer to the way that "scientific and technical work is made invisible by its own success" (Latour, 1999, p.304). When a machine runs efficiently or an object is "unproblematic" (Latour, 1987, p.131), or when a fact is settled and "well-established" (ibid), then the focus is on "inputs and outputs" (Latour, 1999, p.304) rather than internal complexities. For instance, prior to the 3GOC controversy, the focus was on the efficacy of the pill to prevent pregnancy in many women (output) who used OCs every day (input). During the controversy, the focus shifted to the internal complexities of OCs, especially 3GOCs which contained certain hormonal steriods which were isolated as

problematic. Something becomes 'blackboxed' once many elements become a durable whole by "act[ing] as one" (Latour, 1987, p.131). This is significant because when something acts as one, a problematic element(s) (for example, the type of hormonal content in OCs) becomes 'invisible' and does not attract scrutiny.

'Blackboxing' was ubiquitous before and during the 3GOC controversy. Prior to this medical controversy, 3GOCs were "unproblematic" for many users because the safety of this formulation was presumed to be a "well-established fact". The internal complexities of the pill's chemical hormones, for instance, were hidden from view. These were figuratively dark, hidden, covered up: blackboxed. The deaths of New Zealand women who had been taking 3GOCs prised these blackboxes open and subjected them to debate and scrutiny.

'Blackboxing' is a technique that sits easily within the 'modernist settlement' because this concept's primary aims are to stabilise 'facts' and ensure the incontrovertible objectivity of objects. The postmodernist impulses discussed above are anathema to attempts to engage in 'blackboxing'. During the 3GOC debate, the vocabulary of the medical profession and researchers was suggestive that they were attempting to re-box 'facts' and convince users that it was appropriate to focus only on the pill's inputs and outputs instead of its internal composition. For instance, one of the medical professionals I interviewed, Doctor X (interview 14/9/2000), refers to "data that is definitely secure", and Doctor Rosemary Reid, a Christchurch medical specialist (interview 31/8/2000), states categorically that certain statistics pertaining to mortality and 3GOCs are "solid". Here, both the doctors' comments suggest that it is possible to push the questionable data back into their appropriate locations as stable, durable 'facts'.

The medical profession is primarily concerned with the statistical risks, such as the "infrequent" (*Medsafe*, 1999) occurrence that only "1 [woman] in 30,000" (ibid) each year will develop a blood clot. When new problems present themselves, such as those raised by the 3GOC controversy, the first problem solving technique is often to start with these statistical blackboxes. The aim is to rearrange the existing blackboxes into an appropriate pattern in order to solve the problem. If the data is "secure" and "stable", as alleged, then one can simply shuffle blackboxes around without actually opening them for further, detailed scrutiny.

Blackboxes come in collections with other, related blackboxes, much like Russian dolls,[4] in that it is possible to remove one blackbox or doll and find inside it a smaller, but similar blackbox or doll. Modernist settlements, blackboxes and

Russian dolls do not lend themselves to disruptions that try to alter the way that they were originally made. If you do not believe me then try to replace the dolls in a way that was different from the way that they were removed. Such "secure" and "solid" arrangements do not take kindly to these disruptions!

It is worth pursuing a note on temporality here. This study explores the ways that OC users, in particular, deal with and make sense of the 3GOC controversy. What happens, for example, when they realise that a fact that they thought was settled, such as the safety of 3GOCs, becomes destabilised? Although it would be possible to do a study pursuant to the ANT model, (where the focus is the earlier periods of fact construction and how facts get 'made'), this is not the focus of my thesis.[5] Instead of taking 'facts' "back to where they came from, to the mouths and hands of whoever made them" (Latour, 1987, p.25), this study's focus is on one method that consumers utilise to make sense of the controversy: bricolage.

Bricolage can be conceptualised as a postmodern notion for the following reasons: it is inherently messy, resisting cohesion, it reappropriates 'second hand' signs, and it is "ever-mutating" (Weinstein & Weinstein, 1993, p.230). In the process of making do with a stock of signifiers, bricoleurs piece together systems of meanings that do not resemble binary oppositions. The bricoleur constructs deregulated meanings which are subject to dispersion and endless transformations, such as "adding to" (Cindy Carmichael, interview 24/8/2000) and subtracting from medical folders "almost every day" (Cindy Carmichael, interview 24/8/2000). The bricoleur creates a strategy for living and coping with the 3GOC controversy by cobbling together whatever meanings can be wrested from the shards and fragments that are left over from, for example, the 3GOC controversy.

Crucial to the process of bricolage is the accessing of information and the tools in the toolbox. However, as I have explained, "the public" as identified by Doctor Rosemary Reid (interview 31/8/2000) are often discouraged from opening and interrogating these 'blackboxes' and, indeed, 'blackboxes' invariably have a complicated series of metaphorical locks on them. Jacqueline (interview 25/8/2000), a former OC user, imagines that important medical information is literally boxed up or locked away. She elaborates as follows:

> I think that the problem is that women aren't actually informed. I think that they are made to feel that the people who are in authority keep the information. I think that the medics keep knowledge to themselves, locked up, stored away and they only talk to each other about it. We aren't supposed to know about our own health or bodies. It's so hard for us to get into these secret safes of information.

Compare Jacqueline's description of 'secret' information to that offered by Doctor Rosemary Reid, the medical specialist interviewed for this study and cited above:

> It's good not to be paternalistic and withhold information from patients...But I do think that the information in this particular debate has been misrepresented and I think that's just as harmful as hiding something in some ways. I think that it would've been better to keep the information away from the public until it had been looked at and settled by specialists...I know some people even went on the Internet and looked at information. That is sometimes quite dangerous because they're not sure how to interpret things. Medical things can be quite uninterpretable to non-medical people.

Although Doctor Rosemary Reid concedes that "withholding" data is problematic and "paternalistic", she, nonetheless, oscillates between disclosure and the 'dangers' supposedly connected with divulgence of medical information to consumers. Indeed, it seems that despite her reservations about "hiding" information from consumers, Doctor Rosemary Reid eventually decides that keeping "these secret safes of information...to themselves" (Jacqueline, interview 25/8/2000) is in the best interests of "the public". Her concern centres on whether medical information is "settled" or "uninterpretable" [sic]. "Misrepresentation" can be "harmful" according to Doctor Rosemary Reid. Her comments suggest that her concern is that the proliferation of signifiers will be open to a multiplicity of meanings. This is boxed up and called "misrepresent[ation]".

But 'bricolage' does not just involve people accessing information and 'blackboxing' is not just about people hiding information, as in the example above. What is 'blackboxed' is what scientists and doctors take for granted. Attention is not paid to the internal dynamics because assumptions are made about how things work. Doctors and scientists do not bother with their assumptions about how things fit together until there is an unexpected output.

Bricolage involves opening and appropriating 'blackboxed' medical information for its own sense-making purposes. Bricolage may involve lifting the metaphorical lids of blackboxes and investigating the contents. But it is important to note that this process involves accessing information from different sources, a lateral action, rather than delving deeply in 'blackboxes', as I point out later in this chapter. Furthermore, bricolage can be disruptive of 'blackboxes', but it does not have to be. Nonetheless, the bricoleurs' work of examining details within 'blackboxes' (albeit less deeply) is related to what gets done by engineers doing 'white box testing' (Myers, 1979; Beizer, 1995; Wallace, 1986). This is a type of testing that is conducted by software engineers. The essence of this process is as follows: when an engineering product is functioning correctly having been 'white boxed tested', the 'black box testers' only need focus on its inputs and outputs. However, when 'field

failures' occur and something malfunctions, the 'white box testers' must re-examine the intricate workings of the product. Both blackbox and whitebox testing are test design methods. Blackbox testers treat the system as a blackbox in that they do not explicitly use or investigate knowledge relating to the internal structure. Blackbox testers usually focus on function requirements. Hence, this system of testing is also referred to as "functional", "opaque boxed", or "closed box" (Beizer, 1995, p.8). White box test design, by contrast, allows the tester to peek inside the boxes and focus specifically on using internal knowledge of the software to guide the selection of test data. Synonyms for white box testing include "structural", "glass box" and "clear box" (Myers, 1979, p.12). During blackbox testing the internal code is hidden and inputs and outputs are examined, but whitebox testers look specifically at the intricate workings of the programme.[6]

Borrowing from the notion of 'white box testing', this study invokes what I have called 'whiteboxing'. This activity is not 'testing' per se, but a close examination of the inner contents of blackboxes that are comprised of sign systems, knowledges, information, meanings. Prior to the 3GOC debate (and despite historical controversies about OCs), many of the key actors in this field (consumers, doctors and scientists) thought that 3GOCs were problem free and, consequently, it was satisfactory to focus only on the pill's inputs and outputs. However, the deaths of several Aotearoa/New Zealand women (drastic 'field failures'!) lifted the lid of the 'blackboxed' 'facts' pertaining to risks and side effects and prompted further whiteboxing. This involves looking at how the pill works, how it interacts with different female bodies, what its chemical composition is, and addressing the previously hidden 'structures', or epistemological underpinnings, of the object or 'facts'.

The notion of 'whiteboxing' is useful for a study of a medical controversy.[7] What gets done in a controversy includes rigorously unpacking the previously solid, timeless certainty of particular meanings and 'facts'. One thing that happens in a controversy is that people ask questions, examine and scrutinise the proliferation of claims that emerge from the previously neatly packaged blackboxes. The synonyms for the two systems of testing are pertinent here. Whereas, blackboxed information has the effect of making some consumers feel as if this knowledge is "locked up, stored away" (Jacqueline, interview 25/8/2000) so as to render them "blind" (Ellen, interview 7/9/2000) or "kept in the dark" (Ginny, interview 31/8/2000), the adoption of bricolage allows consumers to 'unpack' some of the components of these boxes.

The difference between 'whiteboxing' and 'white box testing' is that the latter, in its most pure form, tries to test and solve the whole problem and to understand its complexity in its entirety. Granted, this is sometimes not what occurs in practice, but the aim of white box testing is to take the bits of blackboxes to pieces, examine them and get to the very bottom of the problem 'boxes'. By contrast, as a researcher, I am engaging in a type of 'whiteboxing' because I am selecting certain blackboxes to 'open'. My focus is on the 'boxes' that pertain to knowledge and information construction and appropriation, but this does not mean that these are the only blackboxes that could be scrutinised. There are many blackboxes that circulate during the 3GOC controversy that I have not attempted to 'open'. For instance, this project does not 'white box test' the chemical hormonal components of the 3GOCs. Like the consumers in this study, I, too, have chosen only to explore the contents of certain boxes that pertain to the project 'at hand'.

Bricolage, while sharing some similar investigative strategies as 'whiteboxing', departs from the latter in that bricoleurs are content to only open those blackboxes that are relevant to their problem solving tasks 'at hand'. The exercise of bricolage involves paying equal attention to different pieces of information (such as embodied signs, 'talk' from friends and family, media representations and popular television talk shows) in a way that medical professionals do not. A doctor might invoke statistics on the frequency of thrombosis, but for the consumer as bricoleur, the question becomes whether she is one of those two people in thirty thousand who might suffer from a blood clot. The attempt to answer this question involves acquiring more information about the consumer's own 'body-self', for instance. In addition, a bricoleur frequently does not delve particularly deeply into 'blackboxes'. A white box tester is invariably obliged to delve deeper into the 'blackboxes'. By contrast, a bricoleur is often content with scratching surfaces, peeking and glancing into blackboxes.

This distinction between 'whiteboxing' and bricolage can be illustrated through a comment from Peter Kearns, a Christchurch naturopath and Co-Director of Canterbury College of Natural Medicine (interview 26/8/2000). Peter Kearns argues that "people know what they read in the paper, or on the internet, etc, but in actual fact that's just the tip of the iceberg". He contrasts "substantial, detailed knowledge" with "tip of the iceberg" information. Peter Kearns continues to say that accessing the "real detail" is "complicated and sophisticated" and "takes a lot of digging". The point is that both 'whiteboxing' and bricolage are strategies devoted to "digging" into blackboxes. However, the difference lies in the degree of "digging" that

eventuates. While bricolage might only reach the "tip of the iceberg", 'whiteboxing' aims to burrow and rummage deeply in details.

According to Zena (interview 13/9/2000), the 'limitations'[8] of collecting a multiplicity of knowledges are often a result of both time constraints and "closure" of the controversy for the individual consumer. Zena states that although she would want to talk to a "GP, NFP practitioner, naturopath, midwife, consumers, etc, etc" in order to "really investigate every possible angle", this would prove to be a "complete impracticability" due to "strained time factors". In other words, despite Zena's preferred strategy, she has to 'make do' with bricolage because this is more practical when there are time pressures. She elaborates, saying that she had "quite a decent look at what a few people have said about the debate and some of the statistical data" and she deems that is "enough for [her] to make a decision". Further, Zena says that once she completes this task, for her, "there is no debate now. I've forgotten about it. The problem has been solved to my satisfaction". Once Zena has unpacked the blackboxes pertinent to her own investigations, she can create a new blackbox out of the available signifiers, a (re)appropriation in other words, and create a solution which ends the debate for her. It is my argument that the concepts bricolage and blackboxing, in particular, are useful to a study of the 3GOC controversy because these are a few of the primary notions at work during the debate.

Bricolage is a metaphor, a conceptual possibility, bent to the purpose of highlighting features of strategic action taken by the majority of the consumers of OCs interviewed for this study. Bricolage is a term applied to the processes and practices undertaken by the majority of this study's participants. However, all the participants do not behave according to what I call bricolage. I interviewed eleven contraceptive consumers. According to my utilisation of bricolage, nine of these consumers can be analysed as bricoleurs and two as contraceptive users who are not bricoleurs. In Chapter Four, I problematise this strict demarcation between those who do and do not engage in bricolage. For example, while Marion (interview 29/8/2000) gives weight to her own embodied 'experiences', she primarily relies upon her doctor's advice. The extent to which people employ certain types of information and which sources are valued, is explored in Chapter Four. In addition, this chapter also compares the strategy of bricolage with other strategies, such as "trusting" (Marion, interview 29/8/2000) the "doctor's expertise" (Marion), which frees a potential bricoleur from the perceived necessity to seek out further information. In a similar way, some of the consumers who do bricolage during the 3GOC controversy, tell stories which indicate that in other areas of their lives they

do not behave as bricoleurs but, instead, "rely on people who know more" (Sarah, interview 26/9/2000) about health care, in this case, purchasing a herbal remedy.

My acknowledgement that I am constructing this study's contraceptive consumers as bricoleurs, stems from an awareness that I am inevitably simplifying the complexity of their storytelling, in part, because I am framing 'reality' rather than innocently reflecting or representing 'reality'. The sense-making of the consumers interviewed, and indeed the meanings that I ascribe to their interview transcripts, are not simple reflections of 'real' meanings. On the contrary, the texts which convey these meanings are the products of social conventions.

'Reality', as a problematic notion, is explored by Allen Curnow (1974, p.63) in his poem "A Window Frame". Curnow's earlier works draw from a realist theory of language. He constructs the poet as a stable, accurate and objective source of perception. And the text of the poem is intended to be like a mirror: transparent, clear, real and true to the reality that he insists exists "prior to the poem" (Horrocks, 1983, pp.30-31). By contrast, Curnow's later works illustrate a shift in his thinking. In "A Window Frame", for example, the narrator of the poem is anxious because he cannot capture and document what he sees outside the window of his house. The narrator's anxiety and confusion increases as he realises that 'reality' is 'messy':

It is not what you say,
It is not the way you say it,
It is not the words in a certain order.

Look out the window.
It is on the page.
Examine the page.
It is out the window.
Knuckle the cool pane.
It is in the bone.
Why is the mud glassed,
With mangroves
Bedded in the glass?
Why is the cloud
Inverted in the glass?
Why are the islands
In the Gulf stained blue
Grained green with
Interior lighting
By Hoyte?
Why not?

The narrator realises that language refuses to perform the function of access to the 'real'. The 'reality' outside the window is inextricably mixed with the 'mess' of intertextuality, situated 'representations' and a self who spills over into the world being 'framed'. The window frame does not innocently frame what is outside. Rather, the narrator is involved in the creation of the 'framing' of 'reality' outside the window frame. When he sees Hoyte colours instead of the 'real' scene, he realises that art

has formed and 'framed' his perceptions. There is no immediate access to the 'real'. The narrator is forced to accept that language is not like a transparent window. He cannot capture a pre-existing 'reality' that is devoid of perceptions, 'framings', 'mess' and constructions.

Like the narrator in "A Window Frame", I, too, recognise that the participants in this study and I are co-producers of 'messy' texts about the 3GOC controversy. We are not reflecting aspects of the controversy as they 'really' are. Rather, we are aware of our 'framing' of the events through the memories and stories we tell. Just as the participants have re-created their lived 'experiences' of a contraceptive controversy through storytelling, I have similarly 'messed' the stories that they transmitted to me. Part of this 'mess' involves taking ideas from a selection of non-modernist writers and running these alongside a medical controversy. And the *reality* of this concession is the realisation that people shape and 'frame' worlds just as those 'realities' and discourses shape people's subjectivities.

Bricolage as practice can be illustrated by paying attention to the self-stories that some OC users utilise to constitute them/selves and their consequent actions. Contraceptive consumers, particularly during a medical controversy, are exposed to multiple sources of information. They engage in a production of the self with whatever resources they find 'at hand'. My focus is on subjects' practices of bricolage as they constitute their selves in and through the varied discourses with which they come into contact.

The constitution of the 'subject' through discourse is a poststructuralist idea (Foucault, 1983; Derrida, 1976; Butler, 1992; Davies, 1997). In contrast to the prediscursive humanist subject, the poststructuralist holds that discourses make subject positions available (Jones, 1997; Davies, 1992; Davies, 1997, Foucault, 1972). Further, the poststructuralist subject is de-essentialised, comprised of multiplicities and contradictions (Kondo, 1990). Contrary to the supposed risks involved in adopting a poststructuralist notion of the 'subject', to "deconstruct the subject does not mean to deny its existence" (Derrida, 1976, p.125). Instead, poststructuralist positions see the subject as a discursive process, rather than as a unique invention. The shift involves reconceptualising the self as a noun to the self as a verb (Davies, 1997, p.274). In the latter schema, the self is always in process, taking shape in and through discursive possibilities. Davies (1997, p.274) summarises the poststructuralist subject as having the ability, among other things, to "see the constitutive process; read the texts of their selving;...look at the contradictions within discourses...; play endlessly with the discursive possibilities

that have been made observable". Such a subject can take up the various subject positions made available.

In Chapter Four, I concentrate on bricolage in action, illustrating the ways that some of the subjects 'interviewed' constitute their subjectivity through the range of discourses circulating about contraceptive technologies and in doing so, make sense of the controversy and embark on actions based on this discursive constitution of self. In Chapter Four, I want to isolate several excerpts from the transcripts to highlight the discursive possibilities through which selves are *made*, not "born" (Haraway, 1989, p.10).

The discourse of risk is a primary example from the discursive toolbox which subjects take up in the production of their selves and decision making during the 3GOC controversy. Risks associated with OCs are circulated through use of an 'immutable mobile' (Latour, 1987,pp.223-227; 1999, p.307) such as a government handout.[9] These pamphlets can become part of the bricoleur's discursive toolbox because they are circulated throughout Aotearoa/New Zealand in health clinics. Such documents are important to the notion of bricolage because they are conveniently 'at hand', part of the discursive toolbox and utilised in bricoleur's sense making and problem solving activities.

The government documents on risks associated with OCs are readily 'at hand' and what Latour (1987, p.224) refers to as 'mobile'. This is because they are easily circulated, sometimes travelling long distances and they are also termed 'immutable' since they preserve stable, 'blackboxed' information without additional distortion. Latour (1987, pp.223-227) also adds that 'immutable mobiles' can be combined with other disseminated information. 'Immutable mobiles', then, are some form of text – pamphlet, doctor's notes, diagram, graphs, writing, pictures – which can be moved but remains stable in different contexts and is often combined with other such texts. These devices are also capable of linking various actors in a given network, such as the State, doctors, OCs, consumers. Latour (1987, pp. 223) explains that these texts permit the "mobilisation of worlds" because they are able to move through time and space. Finally, 'immutable mobiles' – arguably because they comprise the bricoleur's toolbox - are always "conveniently at hand" (ibid, p.227).

The consumer information contained in the Ministry of Health's (January 1992) "advice for women about oral contraceptives" maintains and perpetuates the privileged statistical data pertaining to OC use. For instance, a series of numbers are presented with the agenda of examining OCs critically in order to prove to

consumers that OCs are indeed 'safe'. The *Medsafe* 'immutable mobile' provides a statistical chart which documents the "risk of blood clots per year" that are associated with the various formulations of OCs that could be consumed by the mysterious 'subject' called the "normal healthy woman".

Certain subject positions such as the "normal healthy woman" are made readily available and 'at hand' for consumers within dominant institutionalised discourses. Frequently such positions appear 'natural' and 'normal' and, thus, their certainty and inevitability leads to the assumption that they are immutable. I asked all OC users who participated in this study about whether they received the government handouts, how they accessed them, and how they responded to them. Among the variety of responses I received, some explained that they appreciate "fact sheets" (Heidi, interview 26/8/2000) if you are that "sort of person" (Margaret Kyle, midwife, interview 6/9/2000); whereas others, such as Emily (interview 13/9/2000), Ellen (interview 7/9/2000) and Jacqueline (interview 25/8/2000), found the presentation of risk as an abstraction required combining the 'immutable mobile' with other discursive strategies such as bodily signs. For instance, in an excerpt quoted earlier in this chapter, Emily explains that she felt it was necessary to "put what the figures say in the context of your own body's responses to the treatment" because it is not possible to "simply read the statistics as they appear". And she continues her explanation by saying that "those information leaflets...aren't enough by themselves. You've got to read them with other stuff". Emily's description indicates that 'immutable mobiles' may be combined with other information, but that they are also *mutable*; something which a number of theorists have argued in response to Actor Network Theory's construction of these devices as immutable (Winner, 1986; Singleton & Michael, 1993; Dugdale, 1999).

Following these theorists, I, too, depart from Latour's notion that what he refers to as 'immutable mobiles' are primarily immutable. Rather, I would argue that they are both immutable and mutable. I am referring here to reader/consumer responses to such objects. 'Immutable mobiles' such as consumer leaflets do indeed try to create durable 'facts' and transcend various contexts. However, these attempts at fixing information are not always successful. This is shown through an analysis of what consumers do with such devices. While Latour (1987, p.259) does state, almost as an afterthought, that the "fate of facts and machines is in later users' hands", he does, nonetheless, tend to emphasise the immutability of 'immutable mobiles', rather than highlighting their malleability through consumer responses.

One way to interpret Emily's (interview 13/9/2000) response to the government handouts on the risks associated with OCs is to read it through the lens of bricolage: a concept which relies on the mutability of tools 'at hand'. According to Lévi-Strauss, the bricoleur works with the science of the concrete. It is my contention that, in practice, bricolage involves reaching conclusions from specific examples and accounts, as well as making the abstract concrete. Ellen (interview 7/9/2000), for instance, contrasts herself to what she calls the "blind" consumer. She concedes that she was once also a 'blind consumer', which indicates that her construction of subjectivity is a process. Ellen's subjectivity involves reworking the discourse of risk made available to her through government handouts:

> Yeah, I got those bits of paper. But I just don't think that they mean a thing unless you have bodily awareness... All it is is a bunch of numbers on the page which need to be grounded in your own body's experiences. It just isn't the real me, anymore, to not listen to what my body says to me. I think being conscious and aware of your body opens your eyes up. I wasn't always like this. And, who knows what I'll be like in a few years? But once you're not blind, it's possible to read the numbers on the handouts, bring them back to your own situation, make them yours and really get to the nitty gritty of what they mean.

Ellen (interview 7/9/2000) constructs her/self as a consumer who *becomes* one who is not 'blind'. Furthermore, she could only become a user who is "conscious and aware" by "putting something of [her]self into" (Lévi-Strauss, 1968, p.21) the activity. The 'blackboxed' numerical abstractions that appear on "those bits of paper" do not allow readers to delve into the "nitty gritty" of meanings and self-production. This can only be achieved through a discursive constitution of the self, by making the numbers "yours", and this necessarily involves connecting the abstract and the concrete.

The process of bricolage is intimately connected to the discursive construction of subjectivity. (Re)crafting subjectivities is a component of the practice of bricolage. As a bricoleur gathers various pieces of information s/he makes sense of these knowledges by, in part, placing them in the context of her/his own personal biography and subjectivity. The discursive constitution of self entails taking up available discourses, making "them yours", and the corollary is that subjects often consider the creation to be of their own unique, "real me" (Ellen, interview 7/9/2000) or authentic self. To put this another way, if subjectivity is constructed in the 3GOC controversy primarily through the discourse of risk, then consumers can feel that they are not being true to themselves if they do not incorporate the notion of risk into their sense of self. In *Feminisms and the Self: The Web of Identity*, Griffiths (1995) utilises the metaphor of a web to argue that self-identity is an intricate entanglement of multiple selves. She addresses the question of the possibility of recognising authenticity. That is, just as Ellen is concerned to identify her "real me", Griffiths also writes that the desire to 'discover' the "true me" and to

"be myself" (pp.174-175) are legitimate enquiries. However, rather than conceptualising this 'search' in humanist terms where the self to be found is a unitary, stable, essence, Griffiths argues for selves which have changing cores of being-becoming. As she succinctly puts it, authenticity "requires re-assessing the changing self, not preserving a sameness" (p.185). In Ellen's (interview 7/9/2000) storytelling, becoming her 'real' self involves a process that uses and reuses discursive tools such as risk and bodily signs.

The narrative convention in the consumer handouts that maintains the Cartesian dualism between the compartmentalised head and body is contested by Ellen's (interview 7/9/2000) story which is told through the body. This strategy is similar to Frank's (1995) notion of the 'body-self'. He notes that this phrase comes from Kleinman (p.169). The 'body-self' denotes a rejection of the mind/body dualism, where the former term is privileged over the latter. Frank's argument is that selves are found and formed through bodies (pp.180-181). As such, actors do not tell stories about their bodies, but through their bodies (p.2). The body creates the self. People telling stories about bodies do not simply "describe", according to Frank (1995, p.27). Rather, it is "bodies [that] give their stories their particular shape and meaning" (Frank, 1995, p.27). Ellen's (interview 7/9/2000) reliance on her body's 'experiences' is in itself a discursive strategy. Ellen becomes a consumer who is not "blind" and, thus, one who conceives of herself as authentic and "real", by discursively elaborating on her "body's experiences" in her story about her subjectivity and responses to the controversy.

Frank discusses the ability for knowledges and selves to come 'from' bodies. While I agree with the need to trouble the body/mind dualism, I think that his point would benefit from an inclusion of the idea that discourses also shape embodiment. I am referring here not to bodily constituted narratives, but to a discursively constituted embodiment. A focus on the discursive constitution of embodiment does not eschew the corporeality of physical signs, nor does it deny that there are physiological occurrences that affect people's lives and sense of self. Usher (1997) provides an excellent collection of the debates in social theory surrounding the supposed material, discursive divide. Likewise, Barrett (1997, pp.201-219) considers Foucault's imperative to "dispense with things" (p.201) in favour of words. My argument is that bodily pain does 'exist', but it is the discursive meanings that people attach to embodiment that are vital because meanings are discursively apprehended. An understanding of what bodily signs mean is mediated through, and is the result of, discourses.

Ellen (interview 7/9/2000) has told a unique, 'authentic' story about her 'experiences' with OCs. However, she has composed this story by adapting and combining narrative tools that cultures make available. Her metaphor of the "blind" consumer is arguably a (re)appropriation of a well-established notion of self as psychological consciousness and deep, reflexive (body)-self awareness. The discursive possibility that privileges a self which is not 'blind' is taken up by Ellen. This discourse has a long trajectory from the Torah, to strands of Western psychology, to modernist writings, and feminist politics which encourage women to be knowledgeable, aware and anything but blind.[10] In *Genesis* (2:5), the serpent tells Eve that her "eyes shall be opened" if she eats from the Tree of Knowledge. And later (*Genesis*, 2:7), the Torah tells readers that "the eyes of them both [Adam and Eve] were opened, and they knew that they were naked". The metaphor of seeing/knowing and blindness/ignorance is one which is deeply entrenched in Western culture. Just as Adam and Eve's eyes were "opened" upon gaining knowledge, Ellen (interview 7/9/2000) also refers to her acquisition of knowledge about the effects of OCs as "opening [her] eyes up". The point of this connection between the Torah and Ellen's stories is to illustrate that her discursive construction of self is just that: discursive. She reworks an old metaphor of self-knowledge/seeing by uniquely deploying it in the context of her own "situation". Even in the process of telling her stories to me, Ellen's selves became formed and constituted through the discursive tools that she *picked* up.

I have italicised *picked* and *picks* in order to raise the issue of whether a poststructuralist subject can have agency. Just as Eve and Adam pick knowledge, can consumers like Ellen (interview 7/9/2000) also be said to be actively engaged in picking the discursive tools which constitute selves? This debate is traversed by Jones (1997) and Davies (1997) who partake in a disembodied conversation concerning whether students who use poststructuralist ideas end up invoking a humanist self, thereby eschewing the tenets of poststructuralist thought. As Davies (1997, p.279) convincingly observes in response to Jones, the 'hand' that picks from the discursive possibilities 'at hand' needs to be visible:

> 'Choices' must be made (which tool shall I pick up and how shall I use it, how shall I take up the possibilities of reconfiguration made possible through contradictory discursive injunctions?) She [Butler and by extension Jones] does not, however, make the active, choosing subject remain visible in her text. The invisible hand that takes up the tool in her metaphor reminds me of the invisible women in men's histories of early Australian settlement/invasion, who put the food on the table, who bore the children but were never themselves written about as subjects.

Indeed, the 'invisible hand' and 'invisible women' in Australian history books are reminiscent of Lévi-Strauss' formulation of bricolage, whereby the agency of the bricoleur is circumvented because this figure 'makes do' with what is supposedly

easily accessible and 'at hand'. The taking up or picking up of tools is not determined by their availability (Davies, 1997, p.279). This entails some degree of agency.

Davies also writes that when you are constituted as a powerful agent it is possible to "act powerfully" (p.272). The discourse created by the Cartwright Inquiry's construction of a proactive consumer, for example, constitutes women as potential agents in Aotearoa/New Zealand. Indeed, some consumers interviewed, like Jacqueline (interview 25/8/2000), pick up on this discursive strand and utilise it to produce a self who "knows her rights" and, consequently, is capable of exerting agency in "getting the information that [she] needs". So it is not that nothing exists outside the text (Derrida, 1976) as soon as one pays attention to discursive strategies. What *exists* is a discursively constituted self who feels "in control", as Ginny (interview 31/8/2000) indicated in her interview, precisely because she has picked up a discursive tool which emphasises the possibilities for agency. By taking up the various strands that comprise bricolage, and the constituting of selves that occurs through that process, the majority of consumers interviewed are able to construct themselves as active agents.

But if the subject is picking from a range of discursive possibilities, then the subject must be fragmented, and a question arises about whether this subject has the ability to make a political stance based on his/her 'identity'. Given the currency of this sort of argument (Jones, 1997; Davies, 1997) and the entrenched figure of the humanist subject, it is not surprising that OC users, such as Phillipa (interview 23/8/2000), experience anxiety concerning their fragmented selves. Phillipa tells stories about the difficulty of reconciling her "feminist me"[11] with the discourses promoted by her mother who is Catholic. Since the trope of the 'warring self' (Du Bois, 1969, p.45), who desperately seeks to re-unify her/his essence, is readily available, it is hardly surprising that Phillipa (interview 23/8/2000) expresses anxiety about fragmentation and contradictions within her/selves. Following Flax (1993, pp.92-93), I contend that only multiple, fragmented subjects are capable of "invent[ing] ways to struggle against domination that will not merely recreate it". It is the active picking up of pieces from the mélange of bricolage, and the constituting of selves through that process, that enables emancipation.

It is only through the 'messy texts' of bricolage that active subjects are produced. As Frank (1995, p.58) correctly points out, stories about health are frequently composed of these multiple, *messy* strands, spanning time frames which makes it harder for the listener to pull out the pieces, and organise them (even if

only temporarily). As a researcher, one of my tasks is to pick up some of these threads and look at the ways that consumers use them in the context of a public controversy about medical technologies. In the next chapter the process of constituting selves through bricolage is explored further. It is reiterated that the gulf between theory and practice is imagined. Although a metaphorical, theoretical idea, bricolage is practice: a set of practical, everyday strategies for 'making do' and constituting selves. This stance has led writers such as Latour (1999, p.267, emphasis in original) to posit that the difference between theory and practice is a "divide that has been *made*". Pursuing a similar line of reasoning, the next chapter argues that methodology, theory and 'experience' constitute an intricately connected, but nonetheless 'messy' text. I seek to expand the notion of what can count as a theory-method package by arguing, like Kondo (1990, p.8, emphasis in original), that "experience and evocation can *become theory*".

NOTES

[1] The quote marks here draw attention to many poststructuralist, postmodernist and Actor Network Theorists' resistance to having their ideas 'blackboxed' as theories. This label defeats the purpose of the ideas that they produce.

[2] The theoretical ideas developed through these substantive examples are explored in further detail in Chapter Four.

[3] Please see Chapter Five for an analysis of the sign 'safe'.

[4] Thank you Ima for bringing this to my attention.

[5] Looking at the earlier stages of fact production and construction as this pertains to the original formulation of the pill is the focus of Oudshoorn's (1994) book *Beyond the Natural Body: An Archaeology of Sex Hormones*. She traces the origin of 'facts' about oral contraceptives and concludes that these seemingly incontrovertible statements are actually "made" rather than innocently "born" (Haraway, 1989, p.10).

[6] I am indebted to Karl Willoughby (an electronics engineer who does white box testing) for discussing this technique with me.

[7] For an example see Latour (1987, pp.22-27) for a detailed analysis of the production of 'facts' and their destabilisation through a controversy. Latour's focus in the initial chapters is on the tiny blackboxes that are comprised of statements of 'facts' within facts and the way that they become firmly packaged premises.

[8] The limitations of bricolage that I am referring to differ from those raised by Lévi-Strauss. While I argue that this process is limited because it does not delve as deep into blackboxes as whiteboxing does, Lévi-Strauss holds that bricolage is a "closed" (p.17) and "limited" (p.19) system because it is always forced to rework the same collection of heterogeneous tools.

[9] Please refer to appendix 7 for two examples of the handouts produced by the Ministry of Health which I am calling 'immutable mobiles'.

[10] Even the titles of contemporary films, such as Stanley Kubrick's *Eyes Wide Shut,* play with the metaphor of being able to 'see' through knowing.

[11] Phillipa (interview 23/8/2000) also invokes the discourse of 'choice' during the telling of this particular story. The way that subjectivity is constructed through the discourse of 'choice' is explored further in Chapter Five.

CHAPTER 4

BRICOLAGE AT WORK

Iron Lung

The ventriloquist's breath;
watch, while my lungs compress
it is the concertina pump that sighs.

Not a glass coffin, more obscure,
a dark room I cannot go into
but am locked into from the neck.

The pressure:
your hand on the small of my back,
a whispered imperative, I rise and fall.

The recovery of tension, I dream of it –
through a window, adjacent trains in a station,
how one must be moving if the other is still.

(Greenlaw, 1997, p.35)

The narrator in the poem[1] above expresses the unease caused by not having direct, visual access to her[2] body. While visiting the doctor, she becomes frustrated because she is unable to see into her body. Unlike a "glass coffin", readily available to sight, her body is "dark" and inaccessible. Although her mind and body are seemingly connected, after all she is "locked into [her body] from the neck", her frustration lies with not being able to see/know what is happening in her lungs. The corollary of this blindness and darkness is a perpetuation of the Cartesian split: she is removed from her body. She is not a body, she has a body. The sounds appear to come from another source: it is a "ventriloquist's breath", not her own. And "it is the concertina pump that sighs" not her own 'body-self'.

The anxiety felt by the narrator, when she realises her body is 'dark' and unable to be accessed visually, is connected to a pre-existing, circulating 'meta-narrative'. Vision, in the 'eyes' of much of the Western world, has been privileged over other senses. The practice of making images, for example, as a route to scientific 'discovery' has a long history (Rorty, 1995; Lynch & Woolgar, 1988). The task of medicine is frequently not the elucidation of what the patient says, but what the 'expert' sees in the body.[3] As Frances Price (1996, pp.84, 97) argues, visual imagery is often presented as able to capture "literal reality" and the images produced by the machines are constructed as "truth transporting". In other words, the ability to see the inside workings of bodies provides an authoritative knowledge about the body, which is either difficult or impossible, to gain through other ways of knowing. Seeing (and, by extension, knowing) is a powerful and ubiquitous

discursive tool that subjects take up. Given that this discourse is valorised, it is hardly surprising that subjects express anxiety when they are rendered 'blind'.[4]

Like the narrator in *Iron Lung*, many of the OC users interviewed in this study also express anxieties when they are unable to see/know their bodies and selves. Talk about 'blind consumers' (Ellen, interview 7/9/2000), "hidden" (Sarah, interview, 26/9/2000) embodiment, being "kept in the dark" (Ginny, interview 31/9/2000) and becoming "alienated from [your] body" (Zena, interview 13/9/2000) abound. As Jacqueline (interview 25/8/2000) states, not even the medical profession "can see into the body to check how the pill is working". However, in contrast to the narrator in the poem, most of the consumers interviewed do not feel disconnected from their bodies due to the lack of (literal) visibility. Much of the consumers' talk concerns "listening" (Emily, interview 13/9/2000) to their bodies: a strategy which is conceived as being tantamount to 'seeing' into bodies. Despite the inability of optical technologies to generate images of the pill's workings in their bodies, the OC users interviewed conceptualise seeing/knowing as the ability to 'read' the body. Their subjectivities are primarily discursively constituted. What they see/know about their bodies is inextricably connected to discourses that they take up as their own.

This chapter develops the notion of bricolage at work that was introduced in Chapter Three. I engage with bricolage in action through illustrations of the ways that many of the subjects 'interviewed' constitute their subjectivities through circulating discourses in order to make sense of the 3GOC controversy and make decisions based on their constituted 'body-self'. Although there is a proliferation of readily available discourses within the discursive toolbox, this chapter isolates several primary discursive strategies for analysis. In particular, I explore the discourse of risk as it appears in the 3GOC controversy. I argue that most of the consumers interviewed constitute their 'body-self' by invoking bricolage which makes the abstraction of (statistical) risk concrete through seeing/knowing bodies and subjectivities. It is only by treating bodies as "glass coffin[s]" that it becomes possible to be what Ellen (interview 7/9/2000) refers to as "physically conscious" and, thus, make sense of medical debates and problem solve. While this chapter's focus is on the discourse of risk, the consumer's 'talk' on risk is intermingled with other, often related, discursive tools such as feminism, choice and rights. In this chapter I also explore possible reasons for the uptake of alternative discursive, sense-making strategies because two of the eleven women I interviewed did not utilise bricolage as an interpretative strategy.

Nonetheless, the majority of the consumers interviewed engage in the ingenious '(re)polishing' of various sources of information about the risks associated with OCs: the process that I call bricolage. A bricoleur reworks material that has been "transmitted in advance" (Lévi-Strauss, 1968, p.20) and, therefore, s/he does not necessarily feel compelled to investigate the matter in great depth. For instance, several of the OC users interviewed remark that the risks of 3GOCs are "minutiae" (Marion, interview 29/8/2000) or "small" (Heidi, interview 26/8/2000) when compared with the risks inherent in everyday living. Marion's reasoning is that there is "more chance that [she will] die in [her] car than from the pill!" Marion's and Heidi's talk about risk are adaptations of narrative tools made available to them during the controversy. The government handouts[5] state that the chance of suffering thrombosis as a result of the pill is "rare" (*Medsafe*, Feb 1999; *Medsafe*, June 2000). Similarly, doctors such as Luxi (interview 13/10/2000) reassure clients who are on the pill by diminishing the risks of OCs through comparisons with daily dangers such as "crossing the road or having a car accident".

The comments from Luxi, Marion and Heidi highlight an assumption that people live in what has been termed a 'risk society' (Beck, 1992). Such a world is one in which risks are inevitable. Industrial and technological advances produce risks which go unnoticed and undetected. Beck argues that in this 'risk society' knowledge becomes an economic commodity and that risk is managed by relying on 'expert' knowledge. While expert knowledge is certainly utilised, many of the consumers I interviewed did not rely on 'expert' knowledge alone. Jacqueline (interview 25/9/2000), for example, is not the only participant I interviewed who stated that the consumer is an "expert about her own body". Health professionals like Margaret, a midwife interviewed (6/9/2000) for this study, argue that there is an "equal power base" between client and midwife because the former is the "expert in her own life and body experiences". While Beck does concede that personal risks are managed on an individual basis (1992, p. 33), he does not acknowledge that the management of risks includes consideration of multiple knowledge bases. His treatise on risk disallows the possibility that risk can be assessed with reference to knowledges. Beck's central thesis, in summary, is that risks are diffused throughout society, potentially impacting on everybody.

Giddens (1990), like Beck, also argues that risk is a central feature of contemporary social life. Although there are some differences in their theories, essentially Beck's and Giddens' approaches are akin inasmuch as they describe contemporary social life as characterised by risk. In this time of so-called 'high modernity' (Giddens, 1990, p. 25), risk is a central element in calculations of the

self. The subject in both Giddens' and Beck's accounts is singular, autonomous and rational who utilises 'expert' systems, albeit with some reflexivity, to manage everyday risks. Their contribution to the burgeoning literature emerging on risk is unquestionable. However, their modernist approach has limitations. Despite the proliferation of socio-cultural analyses of risk, the work of Beck and Giddens primarily dominates the field (Douglas, 1990, 1992; Castel, 1991; Luhmann, 1993; Kendall, 1995). In my view, this is unfortunate due to the limitations inherent in these theorists' approaches to science, 'society' and the self.

Subsequent to Beck and Giddens, the recent explosion of writing on risk (Castel, 1991; Rohrmann, 1996; Gifford, 1986; Lupton, 1999a; Lupton, 1999b; Turner, 1995; Irwin, 1995; Parker & Gagnan, 1995; Parsons & Atkinson, 1992) has frequently involved profoundly questioning some of the key assumptions regarding (modernist) subjectivity. A focus of research on risk concerns the taking up of the discursive subject positions of 'expert' and 'lay person' and the ramifications of constituting selves in these ways (Irwin, 1995). Other treatments of risk concentrate on the connections and differences between the contrasting meanings that differently positioned people bring to risk (Gifford, 1986; Parsons & Atkinson, 1992). Castel's (1991) Foucauldian-influenced work also questions some of the key assumptions regarding subjectivity and 'modernity' on which Giddens' and Beck's work depends. According to Castel, there has been a shift from surveillance based on face-to-face encounters to abstract calculations of risk (Castel, 1991, p.12; Peterson, 1997, p.189).

It is my argument that many of the contraceptive consumers interviewed take up discourses of risk by engaging with the 'science of the concrete' (Lévi-Strauss, 1968). The following extract from Sarah (interview 26/9/2000) provides an illustration of the way that the constitution of self, in the context of risk, functions as a way to make sense of discourses and take action during a medical controversy. Sarah explains that she:

> really tries to think more scientifically, in terms of what the literature says about the risks of the pill. But I do think that what other people say, like my friends, influences me. I think that there is definitely a human tendency, which I have got, to take what your friends say as more true than what the literature says. For most people, if you experience it yourself, and then your friends confirm your experiences, you are inclined to make decisions based on this information. But then I also know from my psychology training and that side of myself that it is not as reliable as other sources of information. It is emotionally attractive, but not reliable or accurate necessarily. And yet, I usually make decisions based on my own experiences of pain instead of the research. My head knows that it's not reliable, but emotionally and, in my body, I still listen mostly to friends, family and what my body tells me. The scientist in me is fighting against the other person in me who believes her own experiences and friends' experiences. And it's also that even when I read the literature on the risks of the pill I feel that I have a right to decide for myself what to do, even if it's not what the stats would suggest that it's safe to do. Because, in the end, I have to decide whether I

> think that the stats are applicable to me and my body. It's about what feels right for me. What's more me.

Sandra Gifford (1986, p.224), writing about the many ways that risk is understood and 'experienced' in the case of benign breast cancer, has described the patient's perception of risk as "lived risk". The way that the woman processes, understands and acts on information that the clinician gives her can only be understood within the wider circumstances of her life and her own personal 'experiences'. In the extract above, Sarah illustrates what Gifford calls "lived risk". Although Sarah reads the "literature" about the 'scientific' risks of OCs, she privileges and "believes her own experiences and friends' experiences". Epidemiological research is used to quantify risk by examining the correlation between risk factors (such as age, weight) and outcomes (such as paternal mortality) within a population as a whole. Such statistical correlations may be evidence of, but are not proof of, causation. Health professionals then translate epidemiological risk measurements into guidelines for treating consumers. This is a process fraught with uncertainty because while data can disclose which people are most likely to experience a particular outcome, it cannot determine whether a particular individual will experience that outcome. Consequently, other factors, including "listening to friends, family and what [the] body tells", go into a consumer's analysis of problem solving during a medical debate. As Sarah (interview 26/9/2000) puts it, her final decision about how to respond to the 3GOC controversy relates to whether the "stats are applicable to [her] and [her] body". The information that a health provider can (and indeed is obligated to) disclose to a consumer – and any other such 'official' information obtained – is only one piece of the entire toolbox of information that goes into making health decisions.

Sarah's (interview 26/9/2000) construction of "lived risk" (Gifford, 1986, p.224) can also be interpreted as the practice of bricolage. Bricolage is a concept which relies on the mutability of the tools 'at hand'. A bricoleur reworks information "transmitted in advance" (Lévi-Strauss, 1968, p.20) in order to engage in practical, expeditious problem solving. According to Lévi-Strauss, bricolage is the science of the concrete. Sarah transforms abstract 'literature' on the risks associated with OCs, and makes it concrete by relating it to her own life 'experiences'. Sarah "puts something of [her]self" (Lévi-Strauss, 1968, p.21) into the activity by, for example, "making decisions based on [her] own experiences of pain". Through the discursive constitution of herself as a person who values emotional and embodied information, Sarah appropriates the abstract, makes it concrete and, thus, is able to respond to the risks associated with OCs.

Sarah (interview 26/9/2000) favours the "emotionally attractive" part of her subjectivity. However, she expresses concern that this self is "unreliable" and, thus, is "fighting against the other person in her [the psychologist]". The trope of the warring, 'fighting' selves has a lengthy trajectory in the Enlightenment, modernist West (Flax, 1993, p.92). It is not uncommon for theorists to discuss the conflict and fragmentation of selves. For instance, Kondo (1991, pp.14-17) describes herself as a "living oxymoron" because she is both Japanese and yet not Japanese due to her Americanisation. The presumption that selves must achieve a neat cohesion is inextricably related to the dangerous illusion of a unitary self. Such a troubled subject requires a certain form of self that can be accessed through self-study and the attainment of truth and also a view of 'reality' which is rational and accessible through thought. Further, Sarah's (interview 26/9/2000) rhetorical strategies highlight the importance of discursive practices in the constitution of subjectivity. She has taken up the rhetorical devices that give certain discourses, such as science, legitimacy. Sarah has constructed the discourse of science as legitimate, yet this discourse is in tension with her own and her friends' embodied interpretations. This tension is stark as she struggles with her 'toolbox' and the controversy surrounding the risks associated with 3GOCs.

The perceived tension between different, incommensurable discourses, described by Sarah (interview 26/9/2000) is also highlighted through my own interpretations and writing about the 'talk' of this study's participants. It is frequently difficult to escape the ubiquitous narrative conventions of writing that are invariably resistant to fragmentation. Although I want to speak of a multiplicity of selves, it is easy to slip back into usage of modernist phrases such as the 'cohesion' of subjectivity, and, thereby, disrupt notions of the postmodern constitution of selves. It is difficult to completely jettison the semantic history of the word 'self', as Kondo rightly points out (1991, p.42). For example, as I read Sarah's (interview 26/9/2000) comments about trying to reconcile her "fighting" selves in order to discover "what's more [her]" and her 'real' identity, it is easy to forget that these subjectivities are shaped through her process of storytelling and produced within and by discourses. Even as I try to liberate selves from the confines of modernism, I find myself confronted with the anxieties associated with what Haraway refers to as a "self-induced multiple personality disorder" (1988, p.578). One challenge, then, is to try to enact the theoretical message presented in this study and not simply write about the ways that those who were 'interviewed' for the study constitute subjectivities and are enlivened by multiplicity.

It is my contention that despite the persistence of anxiety surrounding fragmented selves, it would be preferable to treat contradictory elements of subjectivity as evidence for multiplicity. Subjectivity is a discursive effect, rather than a transcendental, unchanging, unitary entity. Since subjects take up multiple discourses in the constitution of subjectivity, it is hardly surprising that subjecthood becomes a heterogeneous and often contradictory experience, which can lead subjects to describe 'fighting' selves. And yet it is only multiple and fluid subjects that are capable of resisting oppressive discourses (Flax, 1992, pp. 93, 110). For instance, not only does Sarah (interview 26/9/2000) take up the discursive possibility of understanding statistics through embodiment, she also constitutes herself as a person with 'rights'. Since she has constituted herself as a person with "the right to decide" for herself, she is able to resist taking up discursive strategies that undermine the importance of her own embodied knowledge. If the subject is constituted discursively through 'rights' rhetoric, for example, then if Sarah fails to take up the discourse of 'rights' she has also failed to attain her 'true' self. In this case, Sarah's (interview 26/9/2000) talk indicates that she feels "right" and "more [herself]" when she attends to the knowledge of her friends and her experiences of her own body.

Subjectivities, who people are, are spoken into existence with every utterance (Davies, 1992, p.73). Stories read, heard and observed, and which have often been "transmitted in advance", form a stock of story lines through which choices can be made. The choices made depend on which story line the subject takes her/himself to be living at that point in time. This strategy is highlighted by some of the ways in which consumers respond to government handouts on the risks associated with 3GOCs. For instance, the following extract from Marion (interview 29/8/2000) illustrates her construction of the professional as 'expert'. She says:

> You do have to trust the doctor because she is the one who knows what is going to be best for you. They have been trained to give you the best advice. I think that it's the same with the pamphlets that come with the packets of pills. Presumably that's all we really need to know to be safe. And with the handouts about the pill and blood clots too. The people who wrote those have the qualifications to know what should be written there. So I just think that I don't have to bother hunting around for anything because it's all there.

Marion's (interview 29/8/2000) talk conveys "trust" for the professional and this, in turn, relieves her of the responsibilities of seeking out further information. She says that "hunting around" for additional information is unnecessary when the information is "all there", readily accessible and 'at hand'. In contrast to the majority of consumers in this study, who have insisted on the importance of adding knowledges to the discursive toolbox, Marion does not utilise the strategy of bricolage because she only uses 'expert' information. She articulates her faith in the

doctor's expertise, based on her/his "training" and "qualifications". Therefore, she considers that it is unnecessary to source other types of information, which is typically part of the bricolage process. As Peter Kearns (Co-Director of the Canterbury College of Natural Medicine in Christchurch, interview 26/8/2000) says, the consumer "has to trust the integrity and the knowledge of the professional because that's why they're there". By taking up her allocated position in the discursive binary of 'expert' and 'layperson', Marion is able to make decisions based upon the information presented to her by the professional. Marion utilises 'expert' information, which can be a component in the bricoleur's discursive 'toolbox'. However, because she relies on and trusts this knowledge, alone, without combining it with other information sources, it is not easy to interpret her strategy as bricolage. Marion utilises a different discourse: one which valorises the doctor's expertise. This is located in different discourses from the ones that are picked up by many of the consumers interviewed in this study. However, Marion is still actively involved in making choices about her future contraceptive decisions.

Indeed, some of the consumers who I have interpreted as bricoleurs sometimes adopt Marion's (interview 29/8/2000) approach outside the context of medical debates. For example, Sarah (whose earlier quotations illustrate that she privileges embodied knowledges and actively seeks out further information about the pill) does not utilise the same strategy when she is purchasing a "herbal remedy". In this case, she indicates that she can "rely on the people who know more" because a "herb, being natural" is less likely to "have such bad side effects as a drug". To be sure it is arguable that Sarah (interview 26/9/2000) has problematically taken up discourses surrounding what constitutes so-called 'natural' substances without question. However, my point here is that the significance of her talk lies in the way that she justifies the different strategies that she uses in various contexts. Whereas during the 3GOC controversy she is sceptical about professional expertise, while purchasing herbal remedies Sarah constructs the professional as 'expert'. Sarah's divergent practices in the different contexts are the product of the discursive strategies that she takes up in each case.

Similarly, Janet (interview 23/8/2000) uses feminist discourses in order to constitute herself during the 3GOC controversy, but she contrasts this with her behaviour when buying a dress. Janet explains the distinction as follows:

> I actually didn't want to go on the pill. This was partly a feminist thing. I just thought, why should I have to be solely responsible? Plus, I thought, it's my body and I don't want it ruined with chemicals from the pill...So that's what I did with this whole thing about the pill. I think you have to be careful when it's your body on the line...But, like I said, if it's just buying a dress, or a car, or something like that, I wouldn't be so fussy and I wouldn't spend so much time, because we're not talking about your own body then. We have the choice to be careful about what we put into our bodies.

Although Janet (interview 23/8/2000) behaves according to bricolage practices when confronted with a medical controversy, she does not deploy the same strategy when "buying a dress, or a car" or something of a similar nature. Janet's utilisation of different discursive strategies is significant because it highlights the way that a contraceptive consumer can occupy a number of different positions simultaneously. Janet constitutes her 'body-self' pursuant to several discursive possibilities presented by, for example, 'choice' and 'feminism'. As Frank (1995, p.64) and Marcus (1994, cited in Denzin, 1997, p.xvii) both note, discursive strategies are rarely neatly deployed. On the contrary, storytelling creates 'messy texts', comprised of multiple discursive strands. The 'talk' of the participants in this study is no exception. For example, attention to embodiment is shaped by the cultural tools at Janet's disposal. If Janet constructs her subjectivity according to the discourse of 'choice', then she is not being 'true' to her 'body-self' if she does not make appropriate and "careful" choices when her body is "on the line".

Janet (interview 23/8/2000) grounds her contraceptive decisions in knowledge based upon her "own body", rather than information that is statistical and perceived as removed from personal, embodied responses to pharmaceuticals. For example, Janet considers "those pamphlets grossly inadequate" because they fail to "tell you anything about your own body". Later in the discussion, Janet added that she also objected to the way that the pamphlets on the risks associated with OCs reduced "women to numbers, because we are people, not numerical figures". Similarly, in a study on UK and USA policies on thrombotic disease and OCs (Marks, 1999, p.1139), a significant finding was that many consumers objected to being constructed by the medical profession and government as "just statistics".

This objection to abstraction is the impetus behind some consumers' decisions to invoke alternative knowledges, such as embodied experiences. For instance, Janet (interview 23/8/2000) makes the "choice to get whatever else [she] could that would tell [her] about the pill that matched how [her] own body was reacting". By engaging with the 'science of the concrete' (Lévi-Strauss, 1968), Janet makes the abstract (statistics) concrete by making sense of the numerical abstraction of risk with reference to bodily signs and personal contraceptive histories. Faced with the abstractions of statistics contained within the government leaflets, Janet constitutes herself as a proactive consumer whose embodiment requires that she access knowledges that 'match' her bodily signs.

Janet's (interview 23/8/2000) talk about the inadequacies of the government handouts and her reworking of the information about risks associated with OCs,

indicates that such documents are both immutable and mutable. The information provided by *Medsafe* (February 1999, June 2000) about the risks associated with 3GOCs can be interpreted as what Latour (1987, pp.223-227; 1999, p.307) would define as an 'immutable mobile'. This is because these documents are easily circulated and disseminated, sometimes travelling long distances (around New Zealand for example) and they are also termed 'immutable' because they preserve stable information with little, or no, distortion. However, various theorists have contested Latour's claim that 'immutable mobiles' are primarily immutable (Dugdale, 1999; Singleton & Michael, 1993). Janet's (re)conceptualisation of the risks associated with OCs made available to her through the 'immutable mobile', highlights that 'immutable mobiles' can also be conceptualised as mutable. In particular, the consumer can transform the supposedly immutable document by "putting something of [her]self into it" (Lévi-Strauss, p.21).

The notion of an 'immutable mobile' stems from the work of Actor Network Theorists (hereafter ANT) who argue that social orderings are constructed by establishing systems of classifications, categories and differences (Latour, 1987, p.171). ANT holds that not only humans but also non-humans can be actors. Actors, both human (for example, doctors, contraceptive consumers, so-called 'alternative' practitioners, drug companies, scientists) and non-human (for example, government handouts, the pill, prescriptions, imaging devices) actively participate in the construction of what constitutes risk.

Dugdale (1999) considers a case of science policymaking about IUDs in Australia. She calls into question the claim typically made by ANT theorists, that a single, stable, immutable view of the IUD is what is presented in the final consumer leaflet. Instead, Dugdale proposes that it is because the consumer information leaflet behaves as an actor, actively constituting its readers as informed users with choices, that consumers respond to the document by making it mutable and unstable. Since they are constituted by the document as active decision-makers, they behave accordingly and do not consider that the information provided is 'true', but part of an ongoing process of negotiation and interpretation.

Similarly, a semiotic analysis of two government handouts pertaining to the risks associated with 3GOCs illustrates that OC users are also constituted as 'informed' consumers with 'rights' and 'choices'. For instance, the February 1999 Ministry of Health/*Medsafe* consumer leaflet on 'Oral Contraceptives and Blood Clots', reminds readers that doctors are "required to discuss the options with you and to explain the risks and benefits". This pamphlet later reinforces earlier 'advice'

by stating that consumers "have a right to expect your doctor to explain the risks and symptoms with you in a way that you can understand". Likewise, the Ministry of Health's/*Medsafe's* January 1999 consumer information leaflet contains the imperative that "women need to talk to their doctors". And this document even has a separate section which canvasses consumers' right to an 'informed choice'. In both documents, readers are constituted by textual moves which emphasise the importance of attaining an 'informed choice', a concept which will be explored and troubled in Chapter Five. The texts are performing their readers in a particular way: as informed consumers with choices, as centred subjects. The texts present themselves as neutral 'information'. And a 'you' is constructed into a centred decision-maker in command of the 'facts' on risk. The facts are presented in order to 'help you decide and choose what contraceptive is best for you" (MOH).

Anne-Maree (interview 18/10/2000) illustrates how the discourse of 'informed choice' presented in the government handouts is taken up by consumers in their constitution of subjectivity. Anne-Maree describes her reading of the Ministry of Health pamphlet as follows:

> I read that information and, like it says, we do have the right to an 'informed choice'. So I went along to my doctor to ask about the pill's risks when I heard about the clots in the paper. But, at the end of the day, it was my choice to decide that the stats just didn't show what was going on in my own body. I decided to look at the numbers and try to put them into myself and my own experiences of being on the pill. I wanted to be informed about the factual risks, but I think that in the end it has to relate to your own body.

Here, the leaflet performs its task as neutral information provider and transmitter of the 'facts' on risks associated with 3GOCs. Furthermore, the consumer, Anne-Maree (interview 18/10/2000), is constituted as an 'informed' user with choices 'at hand'. Anne-Maree is situated as a reflexive self, who can make rational decisions about the costs and benefits of OCs. 'Choice' is presented as systematic. The leaflet is a device that is stable over space and time. It invites readers to "consult" and refer back to it on various occasions. But is this leaflet really totally stable? Since Anne-Maree picks up the discursive possibility presented within the document, she becomes a consumer with 'choices', she constitutes herself as an OC user who is capable of reworking the information presented by "relating" the "factual risks" to her own body and "experiences of being on the pill". Therefore, it is clear that the 'immutable mobile' turns out to be both immutable and mutable. The consumer information leaflet is not merely a transmitter of stable information, a reflection of knowledge made elsewhere. Rather, it is partly because these documents invite consumers to constitute themselves as 'informed' users that they do indeed make decisions to rework the data presented in order to make sense of the debate in terms of their own embodied 'experiences'. Agency is partially

distributed to the consumer who has the responsibility to be 'informed', which, in part, entails involvement in a continuing routine of self-surveillance and checking for signs and symptoms of clots, such as "breathlessness" and "swelling in the leg" (*Medsafe*).

I am arguing that the process of bricolage involves the (re)constitution of selves. Anne-Maree is not essentially an 'informed' contraceptive consumer. Rather, the discursive possibilities presented within the *Medsafe* document invite her to constitute herself as 'informed'. As Kondo (1991, p.48) points out in her analysis of Japanese selfhood, subjectivities are "crafted". They are not given or ready-made. On the contrary, subjects actively pick up discursive strands and craft, construct, modify, work on, change and enact their identities. The 'identity' of a subject is multiple, produced within discourse, potentially contradictory and mutable.

What I am trying to do is make the constitutive power of the discursive toolbox visible. By doing so, it is easier to catch discourses in the act of shaping subjectivities. During one interview with a consumer, she conveyed to me her awareness of the productive capabilities of possible discursive positionings. Emily (interview 13/9/2000) described how she was not inherently an 'informed' consumer, but one who took up this subjectivity as her own. She said that she "knew about the idea of an informed consumer from reading about it in a magazine years ago". And she continued to say that "she thought she could be like that [i.e. informed] too when it came to the pill". And, thus, Emily (interview 13/9/2000) "acted according to the idea that [she] should be and would make sure that [she] knew all about the pill that was necessary for [her] to make choices about how to handle the clot problem". Clearly, Emily conveys her awareness that her 'identity' as informed was not ready-made, as in the modernist model, but that she has actively adopted this subject positioning from the discursive possibilities 'at hand'. By utilising this particular proactive subjectivity as her own, Emily is able to problem solve during a medical debate. Emily's statements suggest that sense-making of medical debates involves (re)constitution of subjectivities and that the 'self' is not essential, unchanging and cohesive, but mutable and produced by discourse.

Being 'informed', according to Emily (interview 13/9/2000), does not just entail the uptake of the enshrined version of 'informed choice' which typically only necessitates knowledge of 'material' risks, as I will canvass in Chapter Five. Like many of the consumers involved in this study, Emily also only considers herself 'informed' once she has made the abstract concrete. She says that the statistics in the government handouts make her "feel alienated from [her] body". Her solution is

to render these numbers pertinent by positioning herself as a consumer who can make choices about what knowledges are applicable to her own 'body-self'. In spite of this study's insistence that many consumers do make the abstract concrete, it is also clear that the construction of statistical risk is pervasive. Why is the enlisting of the term 'risk', in such a specific context of numerical abstractions, utilised so frequently as a discursive strategy?

The abstraction of risk is arguably connected to the erection of surveillance and regulatory systems (Castel, 1991). Castel employs Foucault's notion of 'governmentality' (Foucault, 1991), in constructing an orientation to risk. By focussing on statistical correlations and the factors of risk, instead of the individual, it is possible to "dissolve the notion of the subject or a concrete individual, and put in its place a combination of factors, the factors of risk" (Castel, 1991, p.281). That is, government regulations have moved from an emphasis on the dangerous individual to a new focus on anticipating or preventing the growth of undesirable events and deviant behaviour. For example, during the 3GOC controversy, OCs are constructed as devices capable of regulating potentially sexually deviant individuals who might become pregnant, which is construed as an undesirable event. This is demonstrated on *CTV News* (13/6/2000) through Pippa McKay's comments as chairperson of the New Zealand Medical Association. She describes self-regulation via use of OCs as "wonderful" and, conversely, she says that it is "disappointing" to witness the discontinuation of OCs which has attributed to the rise in pregnancies and their terminations.

By virtue of OCs, the medical profession is able to encourage self-regulation as a form of social management and prevent deviant behaviour/pregnancies. In this process, the individual is effaced and replaced with abstracted statistics such as the alleged rising abortion rates due to previous 'pill scares'. It is not my intention to 'discover' or 'evaluate' whether the statistics associated with the 3GOC controversy are correct.[6] My focus is on analysing the *function* of such a discursive strategy. Why is it important that statistical discourses on risk pervade the 3GOC controversy? How are they operating? It is my contention that the quantification of risk is intended to function as a deterrent mechanism for possible future OC controversies. Moreover, risk as an abstracted concept works to ensure that the 'experts' maintain their statuses as possessors of the 'true' knowledge concerning risks of OCs.

When the 'expert' is deemed the only person who can grasp privileged knowledge, this positivistic approach negates knowledges and the possibility that 'others' can be 'experts' too. Luxi (a Christchurch health provider, interview

13/10/2000), for instance, does not believe that medically or scientifically untrained people can make sense of the 3GOC debate without reference to statistical information which must come from the health professional. She claims that the materialistic-positivistic orientation to the 3GOC controversy is the only possible way to make sense of it. Further, she maintains her position as the 'expert' when she says that "only *we* have got the knowledge" (my emphasis). Her problematic use of the pronoun 'we' signifies medical professionals alone. In Luxi's opinion, it is only these actors who are suitably qualified to divulge the appropriate knowledge to consumers. This is the only way for OC users to come to terms with the debate. Consequently, she insists on the importance of OC users' consultations with doctors about the 3GOC controversy. This is because consumers fail to "perceive or understand what the numbers mean...or they just don't know the stats". There is clearly no room here for a 'death'[7] of the author (Barthes, 1977) which would make room for a multiplicity of 'readings' of the statistics regarding VTE and 3GOCs.

Luxi (interview 13/10/2000) argues that consumers are only ready to make an 'informed choice' once they have received this specific knowledge from their doctors. She says that OC users "need to come and talk to us because we can give them the right information and then say to them go, you are informed now, make the right choice based on the right knowledge". Luxi's repetitive use of 'right' here is suggestive of her presumption that only an epidemiological quantification of OC risk is the appropriate knowledge base from which to reach an 'informed choice/consent'. There is no hint in her remarks, that there are any other valid knowledges which are capable of allowing consumers to make 'informed' decisions. According to Luxi, it is only *right*, that a certain type of knowledge is valued and also that health providers maintain their privileged position as the sole 'experts' concerning disclosure of this information in the controversy.

When doctors argue that it is only important to disclose the 'right' knowledge to OC users, their complaints about the "impossible" (Doctor X, interview 14/9/2000) requirements of 'informed consent/choice' are problematised. What I am arguing is that it is not so much that there is insufficient time available to divulge knowledges, it is just that only a particular type of knowledge is considered worthy of disclosure. Consequently, I would concur that 'fully' informing consumers of the risks associated with OCs is an arduous task (Cartwright, 1988, p.139), but not for the same reasons. First, I would agree with Cartwright (1988, p.139) that 'informed choice/consent' should be the aim "even if the goal is not always achieved". Secondly, while doctors argue that 'full' disclosure is unreasonable because no one else can ever attain their level of expertise, the comments of this

study's participants highlight that medical information alone is insufficient and that other knowledges can be useful in the decision-making process.

In fact, it is often not only consumers who draw on other knowledges, but also those who typically privilege solely medical knowledge: health providers themselves. For example, Sarah's (interview 26/9/2000) description of her futile efforts to get a diaphragm instead of the pill illustrates that, although the 'right' information is invoked, 'othered' knowledges may shape the practices of health practitioners. Sarah visited her doctor on three occasions to get a diaphragm fitted and prescribed and was discouraged each time. Eventually she discovered that it was not the statistics on rates of diaphragm failures to prevent conception that lay behind her doctor's resistance to the diaphragm. Rather, Sarah's (interview 26/9/2000) health provider:

> who is the person who usually fits and measures diaphragms, got pregnant accidentally using one. She [the doctor] eventually admitted this after my third visit! She said that they know it's actually statistically okay for people to use but that she was really reluctant to prescribe it to me because of her personal experience. She hadn't wanted to tell me about her experience at first but I kept coming back...I never got one. I stayed on the pill. The clinic didn't want me to have a diaphragm because one of their staff members got pregnant using one. I thought that was an interesting reason not to prescribe one to me. I mean it's not the run-of-the-mill reason why doctors don't prescribe you something, is it? I can understand, though, why she would take note of her experience and why that would make her cautious. But you just don't expect them to do that.

As Sarah (interview 26/9/2000) notes, the initial reasons underlying her doctor's refusals to prescribe her the diaphragm are "interesting". The "run-of-the-mill" motive for a doctor not prescribing is usually based on accumulated evidence of the impact of particular technologies. This is considered the 'right' type of knowledge to adhere to. However, in this case, Sarah's suggests that her doctor seems to indicate that just focussing on statistics is too narrow. For instance, Sarah suggests that her doctor elevates experiential information above the 'evidence' that it is "statistically okay" to use diaphragms. Embodied knowledge is typically considered subjective and unreliable and, thus, the 'wrong' sort of knowledge to disclose to consumers. Nevertheless, the doctor's "personal experience" of a diaphragm failure, which results in an unplanned pregnancy, is validated as knowledge worthy of consideration and disclosure. Granted, the doctor's reasons do take three visits to surface. Sarah's surprised comment that she did not "expect" her doctor to provide experiential advice suggests that the doctor's reluctance to disclose the underlying reason for her resistance to prescribing a diaphragm lies in doctors' "run-of-the-mill" position that embodied, subjective knowledge is not 'right' for making contraceptive choices. Indeed, Sarah highlights that this is typically the shared position of health providers when she says that she did not "expect" her doctor's reasoning to be based on subjective knowledges. In light of this example, it

is possible to elaborate on the function of the quantitative discursive strategies which proliferate during the 3GOC controversy. Not only do these discourses function to ensure that the health providers' 'expert' (detached, scientific) knowledge is privileged, but they also enable consumers to hide their own tendency to value experiential information as well as – sometimes even over – the 'right' knowledge.

Like Sarah's (interview 26/9/2000) interpretation of her doctor's multifaceted response to diaphragm use, many of this study's contraceptive consumers also demonstrate the necessity of considering a variety of knowledge bases when making sense of risk in the 3GOC controversy. For instance, several OC users I interviewed indicate that statistical constructions of risk are insufficient. Rather than representing the 'real' risk, statistics are conceptualised by Marion (interview 29/8/2000) as constructions. During her 'talk' about the problematic linkage between the 3GOC controversy and rising abortion rates, Marion cites the "classic non-example" which calls into question statistical correlations. This 1920s example holds that "people eating more ice creams caused more deaths". However, Marion goes on to note that causation is frequently not so simplistic and there are multiple variables involved. She explains that it is difficult to "imply causation" from this example and that the "likely underlying cause" would be "that it's summer, it's hotter, there are more people swimming, so there are more people drowning". A significant point raised by Marion's example is that it is inherently difficult to locate the causal relationship(s) that may explain statistics.

However, most of the OC users in this study realise that statistics present these *risks*. They are aware, as Zena (interview 13/9/2000) neatly puts it, that "statistics are like a bikini: what they hide is much more important than the things that they reveal". This statement echoes the oft-cited point that any collection suppresses more than it reveals (Wedde, 1995, p.114). Several of the contraceptive consumers interviewed suggest that what was disclosed during the 3GOC controversy was invariably a tiny portion of what could potentially have been divulged. They were aware of the risk in the assertion that the statistics, despite their suppressions, represent the controversy as it 'really' (Denning, 1994) is. This potential danger is addressed by Zena who stated that "statistics are bent, twisted, shaped so that you can do anything that you want with them". According to Zena's interpretation, statistics are considered unreliable in their constructions of safety.

Consequently, Zena (interview 13/9/2000) does not consider this sort of knowledge, alone, sufficient. Statistics are not wholly 'right' when trying to make sense of the 3GOC controversy. This is primarily because statistics are perceived to

construct and point to covert or hidden risks. Claims by the 'experts' that there is 'no evidence' to support links between certain OC risks and physical manifestations are often dismissed because of the potentially "twisted" (Spirer, 1987) nature of the statistics which substantiate 'expert' conclusions. That is, the standard of proof is sometimes different for OC users than it is in law, or medical science. Consumers, like Zena, realise that statistics are not 'objective'. Like experiential knowledges pertaining to OC side effects, quantification of risk is also fallible.

Furthermore, it is not uncommon for these two knowledges to be seemingly irreconcilable. This is illustrated through Sarah's (interview 26/9/2000) interpretation of the doctor who cannot reconcile the 'fact' that diaphragms are "statistically okay" with her "personal experience" that they fail. Similarly, Zena (interview 13/9/2000) also mixes statistical constructions of risk with experiential knowledge. She contests the elevated status granted to statistics when she insists that they are "just not enough and unreliable" because she is "personal proof" that OCs cause particular side effects despite the 'evidence' encapsulated in the numbers. According to Zena, it is preferable to invoke a variety of discursive strategies when assessing risk. Despite the legal and medical constructions about what is 'material', Zena demonstrates that the standard is multiple and often personal.

Much of the literature that deals with consumer responses to risk also highlights that subjective knowledges are important (Phillimore & Moffatt, 1994; Parsons & Atkinson, 1992; Gabe & Bury, 1996) In particular, Williams and Popay (1994, p.120) suggest that 'lay' and medical practitioners exhibit "different ways of knowing". Specifically, they assert that consumers privilege experience. While many OC users interviewed do privilege experiential knowledge, they often do not do this to the detriment of other information. Rather, they invoke multiple sources of information in order to assess the risks associated with OCs. It is partly due to the limitations of statistics and the recognition that quantification alone is insufficient that causes many consumers to opt for what I interpret as bricolage.

Making sense of medical controversies is, in Zena's (interview 13/9/2000) words, a "lived experience, a life choice". Any meaning attached to risk is temporary and can only ever be provisional. They are the result of a temporary fixing of meaning by the victorious discourse. Yet the victor is not immune to fluidity. Indeed, since the bricoleur's assessment of knowledges, risks, controversies is "lived", rather than abstracted, information is continually being examined, revisited and '(re)polished'.

Many of the consumers in this study tell stories about learning about their 'body-selves' and, thus, resisting the 'victim positions'. The materiality of actively seeking information, assessing risk, and building a patchwork of bricolage is arduous. It is an active rather than passive practice. This is worthwhile stressing because it is easy to mistake the work of an 'artist', such as a bricoleur, as undemanding and effortless, especially when 'art' is associated with the discursive (Beatson, 1994, p.80). Likewise, Ellen (interview 7/9/2000) explains that being active and pursuing "bodily awareness" is hard work:

> Going back to risks again, I have a friend who was four months pregnant before she found out. She was on the pill and still getting her periods and didn't realise that she was pregnant. And I think that is a risk!...So I think that for a lot of women the pill is an easy option, an easy form of contraception. It is so much harder to get all the other information and to learn about your own body. The pill actually denies you this bodily awareness, an awareness of what's going on. Oh, I'll just take the pill and dah, dah, dah, dah. Whereas, I know it's harder but it's better to make the effort to know a bit more about what's going on.

This passage illustrates that the bricoleur's jobs of sourcing "other information" and achieving "an awareness of what's going on" in your 'body-self' is "harder". Ellen (interview 7/9/2000) constructs the pill as an "easy" choice, but also a risky one because it "denies" embodied knowledge which is an important component in the discursive toolbox. Ellen uses her friend's story to highlight the danger posed through an exclusion of bodily knowledges. She becomes pregnant, according to Ellen, as a result of her failure to embrace the practice of including a variety of discursive strategies. To be like Ellen's friend ('blinded' by the pill), is to accept the "victim role" (Emily, interview 13/9/2000). When there is a lack of "bodily awareness" there is simultaneously a lack of control which is not empowering. But a rejection of victimhood is recognised as "harder" because it involves ongoing "effort".

Part of the "effort" involved in attaining "bodily awareness" entails rigorous self-surveillance. Many of the OC users regulate their 'body-selves' so that they avoid the regulation of 'experts'. This is Foucault's (1977) panopticon at its best: the omniscient 'eye' of the 'expert' induces users to regulate themselves. Indeed, the ubiquitous discursive tactic adopted by government and medical practitioners that "prevention" (Pippa McKay, *CTV News*, 13/6/2000) of pregnancy through OC use is preferable to termination, instils in consumers the burden of responsibility. They feel "guilty" (Jacqueline, interview 25/8/2000) if they are not on the pill because if they become pregnant it will be perceived as their "fault" (ibid) since it could have been prevented through disciplined OC usage. This rhetoric is taken up by some consumers interviewed as they constitute their subjectivities. For instance, Ellen (interview 7/9/2000) comments that the notion of the state being responsible for its

citizens' health is outmoded. She argues, instead, that individuals should take responsibility for regulating and protecting themselves from risks:

> It's people's responsibility to find out all they can about risks etc. I do think that it is everybody's responsibility to look after themselves, as much as it is the state's or the government's or whatever...I think that people are capable of getting all sorts of information and being responsible and sort of owning their own decisions...I mean the health provider still has to give some information, but consumers can't rely just on this. The patient has to proactively seek information as well. If people get pregnant when they're not on the pill then they are just stupid. Well, no, I don't mean stupid, that's harsh. But they obviously didn't have enough information or know about their own bodies. They can't have known that there are other options apart from the pill either. This is why it's so important to get all the information you can and then work out what is best for you to do. What I decide won't be what everyone decides. I mean I'm at risk of different health problems than other people.

In this excerpt, Ellen's (interview 7/9/2000) demand that consumers engage in self-surveillance highlights Foucault's (1977) point that surveillance can be exercised without any force, or even direct contact, with the actor from the omniscient, outside institutions. Ellen insists that it is "everybody's responsibility to look after themselves, just as much as it is the state's or the government's". In other words, a form of power is operating here that is redolent of Foucauldian versions, whereby power is localised over the singular body and the reliance is not on brute force but on quasi-voluntary acquiescence. Having gathered their disparate knowledges, bricoleurs then engage in decision-making which involves 'making do' with an assessment of the information 'at hand'. The evaluation of information occurs through self-surveillance. Health consumers make decisions by weighing up information based on a complex and ongoing process of surveillance of their bodies and selves. This is part of the process of bricolage at work.

Not only do bricoleurs have to collect information, but they also have to embark on the task of evaluation in order to "work out what is best" for the individual 'body-self'. As Ellen (interview 7/9/2000) explains, this is achieved through a consideration of what risks pertain to the 'body-self' concerned. For example, Ginny (interview 31/8/2000) has a hereditary risk of breast cancer. According to Ellen, Ginny's "responsibility" would be to manage this risk by collecting knowledges, weighing them up and then making a decision that will be the most appropriate for her own 'body-self'. Needless to say, such choices pertaining to potentially imminent risk of breast cancer involve continual self-surveillance and disciplined preventative strategies. Indeed, Ginny (interview 31/8/2000) says that she "regularly" conducts her own "breast examinations". She also "keeps her ear to the ground" trying to continually collect any information she can about breast cancer. In other words, she behaves much like the bricoleur who creates a scrapbook of information that might or might not be 'handy' in the future.

Ginny's (interview 31/8/2000) policing of her 'at risk' 'body-self' can be contrasted with the consumers who Ellen (interview 7/9/2000) describes as "stupid". Despite her subsequent concession, Ellen describes these consumers in this way because they fail to take "responsibility" for their own self-surveillance. They do not seek information, or assess it based on self-surveillance. This failure can have dire consequences such as unwanted pregnancies and breast cancer.

The "responsibility to look after" your own 'body-self', instead of deferring to the medical profession and/or government, can involve bricolage and include managing your 'at risk' self. Although Foucault did not canvass risk directly, his writing on 'governmentality' is cited as being closely related (Peterson, 1997, p.192). Moreover, as I have argued, practising bricolage sometimes entails Foucauldian notions of self-surveillance. Whereas Beck (1992) argues that the corollary of a deregulated society is the proliferation of risks, a Foucauldian application to risk would contend that risks abound in a disciplined society and that regulation is required to manage these risks.

My argument, in part, follows the latter, Foucauldian stance. Health consumers manage their 'body-selves' through vigorous disciplinary practices in order to prevent and/or manage risks. This self-management of risk can involve bricolage. However, later in this chapter I discuss the complexities of this position through an analysis of a consumer who engages in 'docile' self-surveillance, but the paradox of the docility is that it is actively chosen in order to become 'healthy'. In this way, bricolage (drawing from disparate information sources in order to 'manage' bodies) is not only a technique that is voluntarily assumed, but it also often conceptualised by consumers as a resistance strategy because it does not simply follow the 'official' policies pertaining to what is the 'healthy choice'. For example, much television coverage was devoted to encouraging women to adopt the 'healthy choice' which was to continue with OCs because they prevent pregnancy. However, some consumers (highlighted, for example by Sarah in the extract below) decide to utilise different sources of information and adopt varied approaches. Despite medical profession and government rhetoric that the 'best' choice for women was to remain on OCs, Sarah (interview 26/9/2000) decides that it is 'healthier' to pursue alternative contraceptive methods. Consequently, bricolage can be interpreted as a resistance strategy that includes both 'management' of bodies and active decisions about what type of 'docility' will best ensure 'healthy' bodies.

It is worthwhile mentioning that such managing of bodies and selves is based on a provisionally prioritised 'body-self'. For instance, OC users make decisions by

assessing discourses pursuant to what is considered "best" for them at the time. In other words, the choice is contingent. It will require further (re)polishing in the future. Certain information is prioritised and a decision is made depending on the 'body-self' given precedence at the time. This contingent disciplinary regime is illustrated by Sarah (interview 26/9/2000). Like some other health consumers, she sources variable, and often incommensurable, sets of information. For instance, Sarah (interview 26/9/2000) makes contraceptive choices based on a collection of knowledges including: discussions with other contraceptive users about "shared experiences", "women's health" books such as *Every Woman's Medical Guide* (1984), the Internet, experiential knowledge, pamphlets ('immutable mobiles'), statistics, medical information, conversations with her partner and work colleagues and, finally, novels and movies.

This extensive list of information is similar to that utilised by other contraceptive users interviewed (Ginny, interview 31/8/2000; Jacqueline, interview 23/8/2000; Ellen, interview 7/9/2000; Emily, interview 13/9/2000). The inevitable inconsistencies in such a collection are not reconciled. Rather, information is ranked based on the temporarily prioritised 'body-self'. Sarah (interview 26/9/2000) describes the self-discipline that is required when collecting, sorting and settling on a course of action:

> I went off the pill eighteen months ago and we have been using more natural methods like condoms and Natural Family Planning. I had been on the pill for so long that I didn't even know if I would ovulate! I didn't know how dangerous it was for me to have been on the pill for so long. I wanted to sort out what was happening with my body and get healthy. It took a long time to work out that that was going to be the right thing to do. I had to find out heaps of stuff about the different methods. And so much of it conflicted but I had to do what was right for me then. It took a lot of energy but I think it was worth it in the long run. We finally decided to go the natural way. It was the right time to choose that option. So I had to have six months of just monitoring my periods and keeping track of dates and thinking that I might want to get pregnant. I want to be healthy for pregnancy. I have to fill out the charts and check the thermometer everyday without fail... I've also cut out alcohol, I'm doing more exercise, that kind of thing. I'm making a concentrated effort to take care of myself and my body. I'm careful about what I'm putting into myself, drugs and painkillers, that sort if thing. I'm fitter and healthier now than I have been for along time. I have generally just decided that it's time to get healthy: go off the pill, exercising, changing my diet.

Sarah's (interview 26/9/2000) rigorous disciplinary regime, which enables her to "get healthy", indicates that managing (or avoiding) risks involves continual self-surveillance. Sarah wants to be "healthy" because she has chosen to get pregnant. Her attention to exercise and "changing [her] diet" highlights her risk-minimisation practices. She wants to prevent potential risks to her own 'body-self' and, by extension, her future baby's health. Achieving this goal involves self-discipline daily and also for extended periods of time. For instance, Sarah had to

"monitor" her periods for "six months" and she has to persist with daily charting, checking thermometers, and "keeping track of dates".

Sarah's (interview 26/9/2000) techniques of self-surveillance are reminiscent of the Foucauldian (1977) 'docile body'. This body is inscribed with meaning and rendered manageable. Foucault (1977, p.136) argues that the 'docile body' is manipulated into a useful body which may be "subjected, used, transformed and improved". In their analysis of the disciplinary techniques which disabled bodies (what they call 'broken' bodies) are subjected to, Shildrich and Price (1996) isolate the tiny bodily details and actions that are scrutinised. They use a section from the Disability and Living Allowance Form to demonstrate their point that no detail escapes the target of disciplinary practices (p.103). Likewise, Sarah has to monitor her body's tiny changes through charts and thermometers "everyday without fail". Just as Ellen (interview 7/9/2000) takes "responsibility" for her 'body-self', Sarah also polices herself.

Sarah's (interview 26/9/2000) behaviour highlights the paradox of docility because she is actively engaging in disciplinary practices, chosen in order to become 'healthy' (Bordo, 1993). Not only is Sarah 'docile' because of the self-surveillance practices, but she is also active because she "*decided* that it is time to get healthy" (my emphasis). Sarah's decision is to actively engage in practices that have the potential to render her body 'docile' in order to attain a 'healthy' body.

Sarah's (interview 26/9/2000) enacted decision is also an explication of Foucault's (1988) 'technologies of the self' concept. This notion involves actors "effect[ing] by their own means or with the help of others a certain number of operations on their bodies and souls, thoughts, conduct, and a way of being, so as to transform themselves" (p.18). The decisions that health consumers make about their contraceptive practices involve transformations of their bodies and selves. They ontologically recraft themselves. For instance, when Sarah decides to shift from OCs to NFP, the "operations" on her 'body-self' are extensive. Her "concentrated effort to take care of [her]self and [her] body" enables her to redefine her 'body-self'.

The contingency of each decision and transformation is demonstrated through Sarah's use of "right". Her repetitive usage of this word highlights that her decision is made depending on what is appropriate for the prioritised 'body-self' at the time. On the one hand, Sarah explains that the pill was the "best option" for her "during a time in [her] life when it would have been very inconvenient to become pregnant". On the other hand, she describes her subsequent shift to NFP by saying

that it was the "right time" for her 'body-self' to opt for this choice. In both cases, the toolbox still needs to be evaluated based on what seems "right" at the time. What I am arguing is that bricolage is not just about collecting and reworking disparate discourses. The process also requires an active engagement with incommensurate sources in order to make choices which will be based on whatever 'body-self' is prioritised at a given phase in a consumer's life. In Sarah's (interview 26/9/2000) words, the information that she collects frequently "conflict[s]" but she proceeds to make choices based on what is "right for [her] then". This decision is by no means final. It will need further (re)polishing. The practice of bricolage is an ongoing process.

Authenticity of subjectivity requires reassessing the self, not simply preserving the existing self. Consequently, Sarah (interview 26/9/2000) talks about how her shift from the pill to NFP is involved in creating what she refers to as "a new me". As Griffiths (1995, p.191) eloquently puts it, it is "hard to say how many makers there are and where all the pieces came from" in the constitution of the 'webs of identity'. The primary purpose of this chapter has been an exploration of some of the discursive strategies that OC users in this study utilise in order to construct their subjectivities and, thereby, make sense of a medical controversy. The 'patchwork' of selves is achieved when subjects take up discursive possibilities as their own. Many consumers 'interviewed' feel more 'real' and less 'blind' when they make the abstract concrete by paying attention to their bodily signs. In doing so, the crafting of selves, albeit from a pre-existing discursive toolbox 'at hand', involves the creation of subjectivities that bear the 'unique' mark of the maker. However, this is not to say that the consumers interviewed are essential bricoleurs, but that I have constructed them as strategic bricoleurs, ingeniously combining various knowledges to solve problems.

I have argued that bricolage is one possible strategy that is deployed by some contraceptive consumers interviewed who want to render the workings of the pill figuratively 'visible', like the narrator in the poem presented at the start of this chapter. This poem also suggests that the narrator feels more comfortable when she is not in the "dark" (Greenlaw, 1997, p.35), but aware of the workings her body. The next chapter explores the notion of 'informed consent' and argues that many of the consumers interviewed also constitute themselves as aware and 'informed' once they have considered the embodied workings of their bodies, in addition to the 'material', medical 'facts'. The next chapter is also an exploration of the institutional mechanisms and recent legal and medical history that construct for health consumers the subject position of being active agents with 'rights'.

NOTES

[1] I am providing my own reading of this poem, but I recognise that there are a variety of meanings. For example, the narrator's feelings of frustration, confinement and restriction could stem from outside forces, such as medical technology.

[2] The poem does not indicate whether the narrator is male or female. I am identifying the narrator as female.

[3] This is a lesson I learned through having an image of my lumbar spine generated by MRI (magnetic resonance imaging). My assessment of the bodily signs from my back indicated that there was more than met the doctors' eyes in the MRI pictures, but the discourse of transparent and correct representation shifted my questions about meanings and interpretations to statistics and what "*we* [could] see, clearly" in the MRI. Just as Treichler, Cartwright and Penley (1998, p.3) have pointed out, I was also complaining that visibility – provided by the MRI - is not necessarily transparency.

[4] See Chapter Three where I discuss the notion of seeing-knowledge further.

[5] See appendix 7 for the government handouts pertaining to the risks associated with OCs and blood clots.

[6] Quite apart from the fact that I look briefly at the function of statistical discourse, rather than whether the statistics themselves are correct, the latter task is certainly fraught with problems. For example, Doctor X (interview 14/9/2000) argues that the statistics cited in the Ministry of Health 3GOC debate consumer handouts ('immutable mobiles') are "incorrect" and "completely wrong". Furthermore, there are several texts which address the transparency of statistics as accurate representations of 'reality' (for example see Huff, 1973; Spirer, 1987).

[7] This reference is taken from Barthes' (1977) famous statement that the "birth of the reader must come at the cost of the death of the Author".

CHAPTER 5

TROUBLING THE NOTION OF 'INFORMED CONSENT'

> I predict the rise of a more assertive patient who will ask and expect to receive information.
>
> (Cartwright, 1988, p. 174)

> There has to be a balance between the health provider giving the information and the time that they have available and the patient, or whoever, requesting information, or assertively and proactively seeking information as well. And not just medical information either. I mean a doctor's knowledge only goes so far. He or she doesn't know your body like you do. So how can s/he assess the risk for you? In the end, you have to put it all together and do it yourself. That's what I'm talking about when I say that a lot of people are blind about their body and what's going on with their body and that sort of thing.
>
> (Ellen, interview 7/9/2000)

In the statements above, both Silvia Cartwright (in the Report on the Inquiry into the Treatment of Cervical Cancer at National Women's Hospital) and Ellen (interview 7/9/2000) construct an ideal, assertive information seeking patient/consumer. However, Silvia Cartwright and Ellen operate with differing assumptions about *what type* of information should be 'proactively' sought. For Cartwright, a health consumer is disempowered if medical 'experts' do not share information. By contrast, for Ellen, consumers are unaware, or what she calls 'blind', if they do not combine medical information with other sources of knowledge. Cartwright anticipates and predicts patients who will actively seek medical knowledge from their health providers. Ellen also concedes that health practitioners should disclose information to their clients. However, she also recognises that this knowledge, alone, "only goes so far". She advocates the need for a "balance" between different knowledges so that consumers can put it "all together". Framed in these terms, 'informed' decisions about, for example the risk of OCs, can only be assessed through the process of bricolage that I detailed in Chapter Three and Four. This, at least in part, involves piecing together disparate (and potentially incommensurable) knowledge in order to enable the consumer to engage in 'fully informed' decision-making.

The purpose of this chapter is to explore the issues encapsulated in Ellen's and Cartwright's understandings of assertive health consumers, especially as this relates to 'informed consent/choice'. This concept was a pivotal concern when the Cartwright Committee of Inquiry was appointed in the late 1980s as a response to

the *Metro* magazine article by Phillida Bunkle and Sandra Coney (1987, pp.46-68) which alleged poor practice in cervical cancer research at National Women's Hospital, Auckland. This chapter troubles the notion of 'informed consent/choice' encapsulated in the legal precedents. I argue that the majority of contraceptive consumers interviewed for this study suggest that the constitution of an 'informed' subjectivity is possible through the ingenious combination of a variety of different knowledges and not just medical information alone. This positioning is contrary to the primary legal precedents which hold that medical information, alone, is sufficient to deem a consumer 'informed'. This chapter is about those contrasting and, at times, opposing knowledge systems.

I continue my enquiries into what information is valued by differently positioned people and what assumptions underpin these epistemologies. Once a 'fact' or legal precedent, like 'informed choice/consent', is enshrined, its epistemological assumptions become hidden. This invisibility gives these knowledges the appearance of being more 'natural', right, unquestionable and infallible. But by revealing the masked assumptions that produce 'facts', it is possible to argue that these information sources are contestable and potentially unstable, rather than inherently "secure" (Doctor X, interview 14/9/2000) and "stable" (Dr Rosemary Reid, interview 31/8/2000), as has been suggested by two of the health professionals interviewed for this study.

This investigation into the underlying epistemological assumptions has practical implications for the enactment of the 'informed consent/choice' doctrine. A principle of informed consent is that the consumer must be 'fully' informed. I ask what happens when the epistemological assumptions underlying 'full' disclosure of information only include a certain type of knowledge? What is the presumed meaning of 'full' here? If this is the way that 'informed consent/choice' is framed, is 'informed consent/choice' achievable? I also question why certain people privilege particular types of information. How do they utilise the knowledge available to them? For example, how are the risks associated with OCs articulated by doctors, consumers, drug companies and the media? And what are the meanings attached to the risks of OCs that are enshrined in legal precedents?

In order to analyse these questions, it is also necessary to examine the information that gets privileged and legitimised. A perusal of the common law and legislation pertaining to 'informed consent/choice', and its attention to disclosure of 'risk', highlights the law's resistance to what I call bricolage as a strategy for making sense of medical risks associated with OCs. As foreshadowed by the extract

from the Cartwright Report, the preference is to frame consumers as 'reasonable' people (read disembodied entities) who should only *reasonably* want access to one particular sort of knowledge about possible risks. I argue that this assumption requires elaboration to include a recognition of the way that consumers engage with and '(re)polish' (Zena, interview 13/9/2000) a variety of different knowledges. My interviews with contraceptive consumers indicate that they engage with a wide variety of different sources of knowledge (including medical advice) before constructing themselves as sufficiently 'informed' to make decisions.

The promotion of a bricolage of knowledges rather than access solely to medical knowledge, does not undermine the value of medical information on contraception, OCs and their associated risks. It was vital that the Cartwright Report (1988) insisted that health providers disclose medical information. The importance of this decision is a common theme in the interview transcripts. For example, Emily (interview 13/9/2000) thinks that many consumers still fail to attain Cartwright's construction of the ideal 'assertive patient'. She explains that there are "definitely a hell of a lot of women out there who don't feel comfortable talking to their doctors and so they don't go after the information. And unless you *really ask* for it, it's often not offered" (Emily, interview 13/9/2000, her emphasis). This highlights that there are some consumers who fall outside the 'assertive patient' ideal. Therefore, it is certainly vital that consumers' rights to information are affirmed in law.

The strategy of bricolage, then, does not contest the validity of the regulatory frameworks that uphold patients' rights to information. It does suggest, however, that multiple sources of information about health issues, treatment options and pharmaceuticals can often be essential in reaching an 'informed choice'. Proactive consumers often need to invoke the strategy I call bricolage because of the inadequacies of medical knowledge alone. And less assertive actors also need to invoke bricolage strategies because their disinclination to 'ask' for medical information induces them to utilise alternative knowledge bases, such as popular magazine articles and conversations with friends, family and partners. Ellen's advocacy of the technique of combining multiple sources of information recognises the inadequacies of relying on one type of knowledge and troubles the current formulation of 'informed consent/choice' by arguing that 'fully' informed decisions can rarely be made solely on the basis of medical advice alone.

Consumers have often been identified as not being 'fully' informed due to health practitioners' failures to disclose the medical knowledge. For example, in

The Doctor's Case Against the Pill, Seaman (1969, p.73), one of the pill's leading critics speaking on behalf of OC users, attacks the common ways that the pill was prescribed as a violation of the principle of 'informed consent/choice'. Similarly, Coney and Bunkle's (1987) magazine article on the 'unfortunate experiment' that occurred at National Women's Hospital also spoke to the erasure of consumers' rights to 'informed consent'. The article highlights that the women who participated in Dr Green's experimental treatment of cervical cancer were unaware of their involvement in such a clinical trial. They were 'blind consumers' at the extreme end of the continuum. For instance, one of the patients, called 'Ruth' in the article, says that Dr Green "never informed [her] of [the] condition over the years" (p.58) and that "at no time had [she] been fully informed or given any say in the treatment [she] received" (ibid). The primary purpose of the Cartwright Report was to examine the substance of the *Metro* article's claims. A pivotal issue revolved around whether there had been a research programme into cervical carcinoma involving patients, such as Ruth, who participated without knowing or consenting. Without their knowledge or consent, patients were divided into groups which were either treated with radium and surgery or radium and radiation (Johnson, 2000, p.87). The Report found that there had been a study to find out which of two forms of treatment for cervical cancer was the best and her Honour concluded that this breached the 'informed consent' principle (ibid).[1]

Justice Cartwright's advocacy of the 'assertive patient' stance is arguably her attempt to ensure that consumers are also vigorous about upholding the 'informed consent' doctrine. This principle is harder to maintain in the face of passivity or 'victim positions' that are demonstrated by some of Dr Green's unknowing participants. For instance, Ruth describes herself as the "sort of patient who meekly did what she was told" (Coney & Bunkle, 1987, p.46). Antonia Fisher, an Auckland solicitor (interview 11/9/2000), also suggests that a passive stance among health consumers is not uncommon. For instance, when I asked about her professional experiences and interpretation of health consumers' understanding of their 'rights', she said that many of her clients have "little understanding of their rights and very little knowledge about their right to question or challenge" (Antonia Fisher, interview 11/9/2000). However, Peter Kearns (Co-Director and naturopath, CCNM, interview 26/8/2000) draws a distinction between my "generation" and his "lot".[2] He says that the former "ask more questions...and are far less trusting". In part, his explanation for this shift is a result of occurrences such as the Cartwright Report. Whereas his "lot" were similar to Ruth and would comply because "the doctor said so", he argues that this generation do not assume that "these

supposedly fine gentlemen of medicine" are the 'experts' and, therefore, questions are asked and answers demanded.

Nevertheless, the image of the passive health consumer also persists during the 3GOC controversy. The media presents OC users overwhelmingly as 'victims'. The 'victim' trope frequently features in headlines. For example, the *Sunday Star Times* (1990, p.A8) refers to "pill victims [whose] risk factors were missed". Similarly, *The Press* (1999, p.3) talks about a "blood-clot victim [who] advocates tests before [the] pill [is] prescribed". In this article, the author quotes the 'victim' saying that she was "blissfully unaware" of the dangers associated with 3GOCs. The implication here is that failure to achieve 'informed consent/choice' leads to 'victim positions'. It is my argument, nonetheless, that these depictions of OC users as 'victims' negate consumer agency. And further, following Foucault (1982, pp.221-222; 1990, p.96), I argue that the potential to resist power always exists, either as isolated acts (by OC users for example) or as organised political movements. When the possibilities for resistance are not recognised, prickly relationships with 'informed consent' are constructed since passivity leaves little room for ensuring that the doctrine is met. In Aotearoa/New Zealand through the Cartwright Report, related articles and the media, the 'victim' trope (and its uneasy relationship with 'informed consent/choice') has clearly been disseminated into wider 'discursive fields'.

One of these 'discursive fields' is contraception and, specifically, hormonal contraception. While the Cartwright Report focuses on the use of patients for research, the principles that her Honour discusses, and her recommendations regarding patient rights, apply to all health care encounters. 'Informed consent/choice' and the 'assertive patient' re-emerge during the 3GOC controversy. In addition to articles in the mass media about 3GOCs, this study's participants also highlight the ubiquity of the 'informed consent' doctrine. They raised their rights as consumers, specifically pursuant to 'informed consent/choice' as a discussion point quite independently of my questions. This highlights that 'informed consent/choice' has a presence beyond legal discourses and the Cartwright Report, and also that this project's participants consider it an important issue in contraceptive decision-making.

Furthermore, the narratives of 3GOC consumers interviewed for this study on 'informed consent/choice' are invariably interconnected with a resistance to 'victim positions' which they believe compromise 'informed consent'. As Ellen (interview 7/9/2000) unequivocally says, she does not "feel like a victim" because

she simply resolves to be proactive and "just do something about it, just go and get some bits of information". However, the responses of other OC users reveal simultaneous compliance with and resistance to 'victim positions'. For instance, Emily (interview 13/9/2000) illustrates her ambivalence when she remarks that she believes that:

> if a woman isn't able to make an informed choice then perhaps you could see her as a victim because she does not have the right means available to her. *But* I don't like the idea of the 'woman as victim'. *But* at the same time I think that the women who didn't get enough information could be seen as victims of the medical profession's negligence...*But* I definitely think of myself as a bit of a feminist. I think that it is really important for women to be aware, to have different sorts of information, so that they can resist taking on that victim role. This is all that stuff about how with knowledge comes empowerment. *But* for you to break out of the victim role the knowledge has to come from you as well as doctors and other things. You are an expert too. Then you can really break out of the victim mode by doing this. Victim is a really passive word. When I heard it, a part of me just went, oh, yuck!
>
> (my emphasis)

A refusal to be depicted as a 'victim' is conveyed here by Emily (interview 13/9/2000). Her stance is similar to the position eventually adopted by Ruth, who was one of the primary patients involved during the Cartwright Report in uncovering the poor practice of Dr Green[3]. Emily and Ruth, two differently positioned health care consumers, utilise similar rhetoric in order to resist 'dominant' discursive strategies which attempt to construct health consumers' subjectivities. However, Emily's resistance to "taking on the victim role" is shrouded with ambivalence. She oscillates between, on the one hand, the stance that describes ignorance as tantamount to victimhood and, on the other hand, the position (that she identifies as "feminist") which values women's active pursuit of information. Emily's struggle back and forth is indicated by her repetitive use of the conjunction 'but'. Her endorsement of each of the stances is qualified and reflexively critiqued with the narrative that follows the 'but'.

Despite the ambivalence projected by Emily (interview 13/9/2000) in this passage, she does encourage a particular reading of her 'body-self' as a non-victim who is able "break out of [that] role". This indicates that there is *some* validity in Foucault's suggestion that the "target nowadays is not to discover what we are, but to refuse what we are" (1982, p.216). Emily refuses the position of victim and argues for consumers generating information, not just relying on doctors' knowledge. Emily "refuses" the notion that she is a 'victim' and "discovers" and labels a "part" (Emily, interview 13/9/2000) of her/self as a "feminist". An implicit recognition in Emily's 'story' is that feminists have not just been concerned with whether or not women are victims, but also about pursuing changes, being active and tackling and reversing victimhood. Emily also recognises that women in

general might be 'victims' of misinformation or no information at all, while at the same time she is constructing herself as someone who is definitely not one of these 'victims'.

In her adamant refusal to be a victim (something she describes as "yuk"!), Emily (interview 13/9/2000) also defines or "discovers" that she draws from various knowledges. She says that for women to be "aware", they need to draw from "different sorts of information" and this "knowledge has to come from you as well as doctors and other things". Conceptualised in this way, resistance does not constitute a rejection of 'expert' knowledge (such as medical information), but it does constitute a refusal to accept a certain type of knowledge as the only, one true source. Accordingly, 'blackboxed' ('official, 'expert') knowledge and bricolage is not set up as an either/or scheme. This would simply construct another unwelcome dualism. The technique that Emily (and I) are advocating[4] is a bricolage that draws from *both* 'official', 'expert' knowledge *and* other knowledges. In summary, then, bricolage does not exclude, nor is it entirely distinguishable from, 'official' information. OC consumers, like Emily, "refuse" to be victims in favour of being bricoleurs because it is from this vantage that proactively seeking out information from different sources becomes possible.

This overlap between compliance with 'official' information and resistance to a unitary knowledge, is encapsulated in the term 'expert'. Who is an 'expert'? In the 3GOC controversy, the media isolates the scientists, researchers, and ('conventional') doctors as the 'experts'. As an illustration, a headline in *The Dominion* (1995, p.3.) states that the "experts [will] consider the risks of the pill". The article identifies the Health Ministry, medical school professor David Skegg, WHO and obstetrics and gynaecology representatives as the 'experts'. By contrast, in her passage above, Emily (interview 13/9/2000) identifies consumers and her own 'body-self' as 'experts' too. The 'expert' consumer is not a pervasive concept, but it is a recurring oppositional discourse in the 'talk' of many of this study's OC users. As Margaret Kyle, a Christchurch midwife interviewed for this study (interview 6/9/2000) explains, this unfamiliar construction stems from the view that "the consumer is the expert about her own body, life and experiences". Indeed, the way that the 'expert' experiential knowledge of consumers is assessed along with other 'expert' knowledge is highlighted in a discussion that appears later in this chapter and the following chapter on the risks associated with OCs. I argue that what the supposed 'experts' consider as the 'material' risks are often fundamentally different from what OC users decide are significant.

In any controversy, like the 3GOC debate, the supposed 'experts' vehemently defend the boundaries between themselves and 'others' by reinforcing a static meaning of 'expert'. This protective 'boundary-work' (Gieryn, 1983, 1994) is exhibited by Doctor X, a Christchurch health professional interviewed for this project (interview 14/9/2000). He identifies himself as a "scientific purist" who demarcates this self from the 'other' such as "feminists". In his narrative, Doctor X delineates his involvement in 3GOC controversy from the "unnecessary" participation of feminists:

Doctor X: I get the feeling that there are feminist issues at play here. I guess feminists don't like pills in general *(laughs)* because it doesn't really fit in with their lifestyle. Who knows. Or lesbians I should say. That's a bit cynical. I think that there are probably some political things that I don't really understand. But there are reasons why some feminists are getting involved in this debate, which is unnecessary and doesn't really concern them as far as I can see...

Jenny: What do you mean when you say 'feminist'?

Doctor X: Well, I was thinking in particular of Sandra Coney, who has been behind the scenes for quite a long time in this...she is looking for another issue. I don't think that this is an issue. I think that perhaps that might be part of the problem, a lot of people are trying to make it into one...And I'm not sure why her opinion about medical things would be more valid...I'm not sure how she can help inform the public about medical things.

Here, Doctor X (interview 14/9/2000) is articulating the boundaries between the medical expert and lay political commentator. Part of this process involves assigning distinctive characteristics to each realm. In this case, feminists are 'othered'. Doctor X homogenises feminists and fails to recognise any diversity within this category. The slippage from feminist to "lesbian" betrays his assumption that such people do not require contraception because of their (non-heterosexual) "lifestyle[s]".[5] These constructions provide Doctor X with an explanation for why the feminists/lesbians "don't like pills". Their attributes are blurred with the "political", and by implication the non-scientific, as opposed to his own scientific position. Doctor X speaks from a position of scientific knowledge; whereas, Coney speaks from a position of "feminist issues" and politics. This demarcation is used as a justification for his claim that the 3GOC controversy "doesn't really concern *them*" (my emphasis). Such claims reveal one of the results of his boundary work: the reassertion of his authority and legitimacy as an 'expert' on "medical things" such as 3GOCs and the negation of all others.

Gieryn (1994, p.424) identifies four types of 'boundary-work': expansion, monopolisation, expulsion and protection. Doctor X (interview 14/9/2000) is arguably engaging with the latter three types of 'boundary-work'. He maintains his

authority over the risks associated with 3GOCs through undermining the authority of Sandra Coney and 'other feminists'. At the same time, he describes Coney as being "behind the scenes". In other words, she is not in the foreground but in the background. She does not occupy the medical interior, but she may threaten to contest and rupture it. Consequently, he continues to demarcate the boundaries. In this way, the meaning which he attaches to the 3GOC debate is elevated above "*her* opinion" (my emphasis). This eminence is achieved, in part, through discursive strategies witnessed in his careful use of words. For instance, he refers to Coney's 'opinion' which is coded as non-scientific, aligned with synonyms such as 'belief', 'folklore' that sit in a binary opposition with 'facts' and 'clinical evidence'. In addition, Doctor X dismisses Coney's attempt to make the 3GOC controversy an "issue" by saying that it is "not a problem". Coney's 'expert' status and her capacity to 'inform' consumers is subjected to scrutiny, while the medical professional's is not. The assumption underpinning this claim is that only the delegated 'expert' has the authority to ensure 'informed consent/choice' is achieved. However, as I have argued, the 'expert' knowledge is not of sole significance to health consumers.

At this point, it is useful to pursue my discussion of the meaning of 'informed consent/choice' as it has been developed by the 'experts'. 'Informed consent' has become a fundamental requirement of both ethics and law. The essence of the concept is that medical treatment cannot be given to 'competent'[6] patients without their informed consent. The Cartwright Report and much of the prior case law make no distinction between 'informed consent' and 'informed choice'. A solicitor interviewed for this study, Antonia Fisher, explains that the latter concept falls under the same doctrine as 'informed consent' (interview 11/9/00). The standardisation of 'informed consent/choice' is suggested in a paper issued in 1990 by the Medical Council of New Zealand (cited in Collins, 1992, p.65). They define 'informed consent/choice' as a "voluntary, uncoerced [sic] decision made by a legally competent or autonomous person on the basis of adequate information and discussion. This contrasts with the rejection of a proposed course of action; in short, it is a choice". Pursuant to this definition, 'consent' means the same thing as 'choice'. This is arguably an unsatisfactory slippage in some health care circumstances. For example, when a consumer is making a 'choice' about OCs, although she eventually 'consents' to the proposed type of OC, she is certainly not at the extreme end of the 'consent' continuum where completion of a formal consent form is required. The vast majority of case law in this area deals with consent to participate in medical research/experiments. But I do think that it is worth pointing out the fine distinction in the case of contraceptive decision-making. In these circumstances, the emphasis is on the

choices available to consumers, even though she will inevitably 'consent' (informally) to the choice that she makes. Therefore, the law's privileging of consent in this area is not altogether applicable to the 'informed *choice*/consent' conducted by an OC user.

Given the importance of 'choice' in the contraceptive arena, I asked OC users what sort of options their health providers presented when they consulted them about contraception. In almost every case it was clear that these consumers were unaware of the variety of contraceptive methods available to them. In particular, many talked about not being made aware of the different varieties of OCs available. Phillipa (interview 23/8/2000), for example, says that when she first went on the pill she "didn't know the difference between one and the other" and that she was "just told to take that one [a third generation formulation]" so "in the end [she] just ended up doing what he said". Ginny (interview 31/8/2000) describes a similar occurrence when she says that she did not "realise that there were different generations of pills... And I was really surprised when I went back [after the media's release of 3GOC controversy] and found that she [the doctor] had a *whole book full* of all these different kinds of pills. I wish that she had told me about this earlier!" (her emphasis). It is clear that in these two cases, Ginny (interview 31/8/2000) and Phillipa (interview 23/8/2000) did not have the OC options presented to them, therefore, they could not make an 'informed choice'. They 'consented' to use of an OC that they might not have chosen themselves. Moreover, Ginny certainly conveys that she would prefer that these choices be disclosed "earlier", especially when the options are seemingly so vast that there is a "whole book" on different OCs.

Likewise, other OC users also express their desire to have contraceptive methods, other than the pill, disclosed to them. Judith, a Christchurch Natural Family Planning teacher who participated in this study (interview 28/8/2000) says that many of her clients feel "angry" because they go to their health providers to get information about "*all* the contraceptive methods" (her emphasis) but the doctor "pushes them into one particular one, often the pill". This same sense of dissatisfaction is conveyed by some of the consumers interviewed who say that some doctors present the pill as "the only contraceptive, the wonder drug, as if nothing else exists" (Phillipa, interview 23/8/2000). This particular consumer goes on to bemoan not having been told about NFP earlier, which she now prefers to OCs. She learnt about this contraceptive method through a friend rather than her health provider. Judith (NFP teacher, interview 28/8/2000) would not be surprised about this because she says that health professionals regularly give consumers

"biased information". She suggests that doctors fail to meet 'informed consent/choice' standards because they scare potential NFP clients when they unfairly warn that "if they want to have a baby then go and learn NFP". Such failures to meet 'informed choice/consent' induce consumers like Phillipa (interview 23/8/2000) to seek information about particular contraceptive methods from other sources.

Jacqueline (interview 25/8/2000) also discovered NFP through a family member rather than her doctor. And like Phillipa (interview 23/8/2000), she, too, expresses her frustration that this method was not disclosed at the time of her initial health care consultation when the decision-making about contraception occurred. Once she had obtained the information about NFP, Jacqueline went back to her doctor. She describes her 'experience' there as follows:

> I went in there [to the doctor's] to get a referral to NFP. But the doctor sort of bullied me back on the pill. Well, he said that I could do NFP but that I may as well prepare myself for pregnancy because it's not a reliable method. I wondered if he were right about that at the time. But he did keep saying that it wouldn't work. So I went back on the pill, reluctantly. There didn't seem to be anything else. I really felt like I was treated like an idiot and I wasn't listened to.

From Jacqueline's (interview 25/8/2000) perspective, her interaction with her doctor is an example of one of the central shortcomings of 'informed choice/consent'. The legal requirements forbid health providers from manipulating the consumer's choice through selective provision of information, or playing on the patient's fears. Ethically objectionable manipulation, as opposed to what is considered appropriate information and persuasion, aims to produce a different choice from what a competent patient would have made if s/he had freely chosen. According to Jacqueline, the doctor's disclosure of information about NFP is selective. He tells Jacqueline that NFP is "not reliable" and is likely not to "work" and, therefore, she should prepare herself for inevitable pregnancy. Playing on her fear of pregnancy, Jacqueline feels like she is "bullie[d]" into taking the pill. Her use of 'bully' here is indicative of a patient's desire to achieve consent without coercion.

Furthermore, the example recounted by Jacqueline (interview 25/8/2000) highlights the importance of 'discussion' instead of the unidirectional flow of information from health provider to consumer during the 'informed consent/choice' process. It is not adequate to merely be granted a voice. What is important is whether anyone will listen. In Jacqueline's (interview 25/8/2000) case she felt that the doctor failed to listen or treat her 'voice' seriously, treating her instead, as an

"idiot". Here, the dialogue between consumers and health care providers has been ousted by a uni-structured transfer of information from one source to another.

The case law preceding the Cartwright Report, such as *Salgo v Leland Stanford Uni Board of Trustees* and *Canterbury v Spence*, delves into 'informed consent/choice' and tries to counter situations such as those canvassed above by ensuring that the consumer is indeed the person who makes the decision (without coercion). However, these cases frame the definition of an 'informed' consumer in strikingly different terms from the strategy advocated by Ellen (interview 7/9/2000) in the quotation at the start of this chapter. This is an approach to 'informed consent' that holds that the disclosed information must stem from a tightly defined set of 'official', 'expert' knowledge. Jacqueline's doctor considered her NFP choice was unreasonable. By paying close attention to the attempts to hide the epistemological underpinnings of what is deemed 'reasonable' and 'material', I want to illustrate how these meanings are not definitively stable and settled but inherently slippery and subject to scrutiny.

The first effort to officially enshrine information which health consumers should 'reasonably' access gained prominence in America in the late 1950s.[7] Specifically, the District Court of Appeal held in the *Salgo*[8] case that the patient was "entitled to know the nature, consequences, harm, benefits, risks and alternatives [of any treatment] in order to make a reasonable decision regarding whether they would accept or reject a treatment option" (p.48). The underlying philosophical premise of this decision was that the Court believed in upholding autonomous self- determination. In other words, the Court decided that 'patients' had a right to "know" and make a 'reasonable decision' about what happened to their bodies. The early common law identifies that the onus is on health providers to disclose this medical information.

This precedent challenges the precept that health professionals are the "people who have the authority to keep the information" (Jacqueline, interview 25/8/2000) and that they should be the sole decision-makers for the patients. Medical professionals are not cast as being in the optimum position to decide what is best for their clients. As Sarah indicates in her interview (26/9/2000), doctors are often constructed as if they are "Godlike".

The Cartwright Report (1988, pp.127-129) challenged similar notions, 'therapeutic privilege' and 'clinical freedom', which are related to the degree of authority of medical professionals. These two concepts hold that health providers

have discretionary powers to stop short of disclosure if s/he feels that there is a clinical reason to justify this and also that health professionals are the best people to make decisions about appropriate treatments (Townshend *et al*, 1998; Cartwright, 1988, pp.127-129).

Despite Cartwright's conclusion that these ideas about medical discretion are no longer appropriate – or "dead" (Professor Hamptom, cited by Cartwright, 1988, p.129) – there is evidence that they linger on, albeit in slightly different guises, in some drug advertisements. For example, the persistence of a strand of 'clinical freedom' is illuminated in advertisements for OCs in the late 1990s that appeared in the *New Zealand Medical Journal* (24 October 1997, no.1054; 9 October 1998, no.1075). These advertisements (see figure 5.1) emphasise "freedom of choice" in bold eye-catching print alongside the silhouette of a woman leaping in the air, her arms extended in an expression of liberation. The initial reading encouraged by this advertisement is that the 'freedom' accessed is that of the woman. In other words, if women *choose* the brand of OC advertised by the drug company Schering, then they, too, will be able to emulate the freedom of the silhouetted figure. However, these signifiers are juxtaposed by the accompanying small print. Although use of the pronoun "you" seems at first to belong to the outlined 'free' woman, the rest of the print quickly disabuses the reader of that notion. The excerpt states "proudly" that when "*you* choose a combined oral contraceptive *your job* is to choose the progestogen that suits *your patient* best...our job is to provide it" (my emphasis). By the conclusion of this sentence, it is clear that the pronouns actually refer to the doctor's, not the consumer's, "freedom of choice". The image and the print are either in juxtaposition, or the corollary of the doctor's choice of COC for the 'patient' is supposed to lead to her freedom. I would argue that the 'freedom' and 'choice' reside unquestionably with the doctor in these advertisements. They do not even hint at the 'informed consent/choice' principle which holds that consumers are 'free' to make their own contraceptive choices. There is little indication of process or partnership within the health care consultation in these advertisements. In this sense, the *silhouette* is apt indeed since the *substance* of the decision rests with the doctor not the consumer.

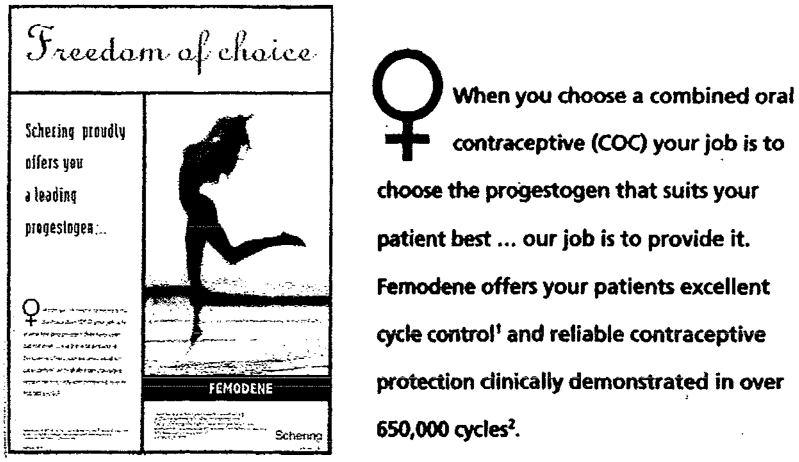

Figure 5.1: *New Zealand Medical Journal*, 9/10/1998, no.1075

The silhouette, which stands in for the consumer, is also appropriate to the dominant reading which the advertisement suggest. The stereotypical female form is consistent with the advertisement's construction of a generic female. For example, one of this advertisement's strategies is to represent women as menstrual cycles. It states that the OCs are "clinically demonstrated in over *650,000 cycles*" (my emphasis). When women equal "cycles", the similarities between females is emphasised. This is consistent with the silhouette which also represents a universal "cycle". By replacing women with "cycles", the drug company is able to associate individual bodies with a universal, generic process, achieving what Haraway would call "sameness" (Haraway, 1991, p. 17). Furthermore, use of "cycles" gives Schering the latitude to make their OCs appear more successful: 650,000 cycles is not tantamount to the same number of women, even though this is the reading that is encouraged by the advertisement.

These tactics are not peculiar to the recent advertising of 2GOCs and 3GOCs. As Oudshoorn (1994) convincingly points out, the researchers who created the original formulation of the pill also represented women as menstrual cycles (p.132). Oudshoorn asserts that this scheme had material consequences. She explains that "cycles" allowed the researchers to stretch their results so that there was a "major increase of scale: the grand totals of the trials [in Puerto Rico] now included much more impressive numbers than a focus on the individual subject might have achieved". The corollary was that the trials could be presented as successful and the pill as 'safe' because the researchers had tested the synthetic hormones on "large numbers of cycles/women over long periods". Likewise, the advertisements' use of "cycles" also promotes the reading that their OCs are safe and successful. The apparent numerical successes presented through the ongoing

use of 'cycles', continues to justify the doctor's 'clinical freedom' when prescribing OCs.

Despite these "presumptions that the doctor knows best" (Jacqueline, interview 25/8/2000), other case law places the onus on the patient to ask questions of the doctor who is then required to provide adequate answers. For instance, this is demonstrated in *Smith v Auckland Hospital Board*[9] which is about a client who was assured that an aortic angiogram would be a low risk procedure. However, during the angiogram the blood flow to his right leg was occluded and the ultimate result was that his leg had to be amputated. The Court held that the onus is on the patient to ask questions which the health provider is required to adequately answer. This standard is often unsatisfactory because it relies on consumers who are sufficiently well informed – in terms of the medical knowledge component - to know what questions to ask. This problem is highlighted by Anne-Maree (interview 18/10/2000), a contraceptive consumer, who has this to say:

> It's hard to know what to ask these doctors. I quite often feel a bit ill or get pains but I don't go to my doctor because I just brush it off and don't know what it is. When I went to the doctor's to get the pill, I didn't know how it worked so I wasn't sure what to ask about. I would've liked to have been told how it works and what the hormones are and do before I took it. I didn't even think about it until the big drama hit the papers. I'd be willing to bet that that is why those women died from blood clots. They wouldn't have known that their sore legs meant they had clots. They would've just thought, 'Oh I've got a bit of a sore leg but it'll disappear.' And even if they did go to the doctor, they wouldn't have known what questions to ask. They wouldn't have thought that it could have been the pill! It's meant to be safe! So, there's definitely a problem with knowing what to ask when you're at the doctor's. You need to have enough medical, technical information, as well as everything else, to know what to ask them.

Here, Anne-Maree (interview 18/10/2000) clearly describes the difficulties faced by some consumers during a health care consultation. In particular, she considers herself to be at a disadvantage since she isn't "sure what to ask" the doctor. This is because she has not received "enough medical, technical information" about the pill from her health provider. Specifically, she has been "kept in the dark" (Jacqueline, interview 25/8/2000) about how the pill "works and what the hormones are and [what they] do". She elaborates on this point by explaining that it wasn't until the 3GOC controversy ("the big drama") entered the media, that she wanted, "would've liked" to have known more. In other words, she now wanted to trace the assumptions that had previously been obscured by the neatly packaged, presumably "safe" OCs. This desire includes looking at the workings of OCs, their intricacies, hormones, and the assumptions underlying medical knowledge that deems 3GOCs 'safe'.

Anne-Maree (interview 18/10/2000) does not merely retell her own private troubles regarding access to medical information. She also speculates confidently (she is even "willing to bet"!) that her frustrations are shared by other consumers. Specifically, she refers to the 3GOC controversy and contends that "those women [who] died from blood clots...wouldn't have known that their sore legs meant that they had clots". That is, Anne-Maree believes that, like her, these women also did not investigate the epistemologies that underpin assumptions. The importance of attending to this is certainly advocated by Anne-Maree, who essentially argues that a failure to interrogate why your body is in pain can even led to death. Anne-Maree considers that these OC users were so unaware of medical knowledge about thrombosis that this 'blind[ness]' contributed to their deaths. Without such information, these consumers "brush" their physiological complications aside and are unaware about "what questions to ask" their health providers. Anne-Maree's (interview 18/10/2000) recounting of this "problem" illustrates the importance of two things: first, that it is crucial to destabilise 'official', 'expert' information (that is supposedly 'secure') by enquiring into underlying assumptions and secondly, that 'informed consent' principles, which hold that doctors have a duty to disclose medical knowledge to patients, are also vital.

Once again, then, my argument is not that the 'informed consent/choice' concept is invalid or that medical knowledge is unnecessary, but that it is one, albeit an important, component in the collection of information that is necessary for a 'fully' informed decision to be made. Furthermore, Anne-Maree's (interview 18/10/2000) reflections also call into question the adequacy of cases such as *Smith v Auckland Hospital Board* which place the onus of seeking medical information *entirely* on the client. This is not to say that the consumer should not ask questions and seek explanations for underlying epistemological claims. What I am suggesting is that placing the onus solely on consumers, so that doctors are absolved from responsibility, is an unsatisfactory solution.

The inadequacies of such solutions are recognised in the American decision *Canterbury v Spence.*[10] In this case, the nineteen year old plaintiff was admitted for back surgery for a suspected ruptured disc. There were complications with the surgery, namely partial paralysis, ataxia and incontinence. These 'material' risks were not disclosed prior to the operation. The Court held that the patient would not have consented to the surgery if these risks had have been disclosed. This was a seminal decision in changing the focus of 'informed consent' from the 'reasonable doctor' standard to that of the 'reasonable patient'. The Judge held that the

practitioner had a duty to supply the patient with all the information that she might 'reasonably' need to assist her decision-making.

As the cases *Salgo v Leland Stanford Uni Board of Trustees*, *Smith v Auckland Hospital Board* and *Canterbury v Spence* show, the standard of the 'reasonable person', and what such a subject should 'reasonably' expect, is a fundamental legal concept which is frequently invoked. The 'reasonable person' standard (in the context of medico-legal issues) generally involves viewing acts in the light of what 'reasonable people' would be expected to do and not in light of what the particular individual might do (Greenawalt, 1992, p.4). This test is supposedly 'objective'. The 'reasonable person' becomes the 'unmarked' (Haraway, 1991, p.17) category. An investigation into the assumptions that underpin the 'reasonable person' standard reveal that this subject is *made*[11] not given from a very specific set of epistemological and ontological tools. In other words, the figure of the 'reasonable person' is the product of discourse, constructed from readily available, familiar and enduring narratives. I am referring here to the dualistic tendencies of Western logocentrism. The reason/able person encapsulates the binary opposition where reason and mind are privileged over the body, the sensual. The 'reasonable person', then, is a disembodied entity.[12] This person cannot tolerate a multiplicity of selves because the standard presumes the subject to be unified, consistent and homogeneous. The 'reasonable person' is "everywhere and nowhere" (Haraway, 1991, p.163), representative of the ideal consumer who makes reasonable and rational decisions.

Such 'reasonable people' are also supposed to make these nonsubjective decisions based on a very specific type of information that the courts deem 'material'. So the law constructs this standard of the 'reasonable person' and also decides which knowledge such a person should 'reasonably' wish to access and utilise. It should be no surprise that the courts have decided for these 'reasonable people' that the information they require is knowledge that is valued for its disembodied nature. This typically includes 'scientifically proven' and statistical 'evidence'. Such knowledge is considered 'material' and worthy of disclosure to consumers. For example, the Australian case *Rogers v Whittaker*[13] held that the giving of information was to be driven by the health, temperament and information needs of that particular person. In this case, a new test for 'informed consent' was developed to determine whether a risk was material and, thus, should be disclosed. The court held that a risk is 'material' if "in the circumstances, a reasonable person, if warned of the risk would be likely to attach significance to it or if the doctor is or should reasonably be aware that the particular patient, if warned of the

risk would be likely to attach significance to it" (p. 433). The implication here appears to be that, if a patient would consider a risk significant, then that will be the test regarding whether it should be disclosed. In practice, by invoking the 'reasonable person' (who is supposed to value a certain type of rational, disembodied information), the test maintains that the doctor is permitted to presume that s/he only need disclose what risks are statistically probable. In other words, it is presumed that a 'reasonable person' is only "likely to attach significance" to those risks which are 'material' (read scientifically proven and statistically likely given clinical evidence).

Pursuant to the legal (by virtue of the scientific) definition, a 'material' risk is also only one which is deemed to be 'major' rather than 'minor' according to clinical testing. Dr Rosemary Reid, a Christchurch doctor who participated in this study (interview 31/8/2000), explains that, medically, a 'major' side effect is "anything that interferes with lifestyle"; whereas, a 'minor' side effect is "something which tends to go away after you have been on [the drug] for a while". According to these definitions, major side effects associated with OCs include "thrombosis, heart disease, stroke, breast cancer" versus "nausea, bloating, irregular bleeding" which are classified as minor side effects. The risk of experiencing such side effects is assessed clinically and then categorised as either 'minor' or 'major', largely according to statistical probability and the numbers in the sample who experience particular side effects.[14] A Christchurch doctor interviewed for this study, Luxi (interview 13/10/2000) explains that the likely risk of side effects (mainly minor) is "measured" by "relying on doctors' notes". She continues to clarify this by way of an example:

> Say I was doing a study in this clinic. Then I would have to dig out the notes for everybody on the third generation or whatever. And then go through the notes. If someone has no problems, then you would write 'no problems'. Or if there is bleeding, weight gain whatever. So you would have to go through the notes. Because it is difficult to say to someone, okay you're starting on the pill today and here's your diary, keep a note. Then it becomes rather subjective doesn't it? It is very difficult to make it objective because you are asking them to ask themselves if they have any problems. I mean they would say, um, I feel a bit sick today. If you were to give the person a chart and say can you tick or whatever, I think that they would be more subjective because they are faced with this everyday. There are far too many changes. They will be searching for an answer, a side effect, an experience. As a doctor, you can't know if this is really a real side effect or risk that the patient was experiencing. This is an unreliable method. So I think that the closest way to get objectivity is to go back and look at the records because these stay the same.

In this excerpt, Luxi (interview 13/10/2000) describes the recognisable characteristics which are typically associated with doctors/scientists and patients. She represents the doctor as a detached observer who has the remarkable ability to transparently record 'reality' in her/his notes. Conversely, the patient is depicted

as an "unreliable" source of information since his/her knowledge is bodily, "subjective" and, thus, cannot possibly be "charted". Quite predictably,[15] subjectivity and objectivity are set up as an incompatible coupling. Luxi (interview 13/10/2000) is appealing here to the dominant epistemologies of modernity, with their Enlightenment legacy and later infusion with positivist-materialist principles, which have defined themselves around ideals of pure objectivity and value-neutrality. These ideals are best suited to govern evaluations of the knowledge of knowers who can be capable of achieving a view from nowhere that allows them (through the autonomous exercise of reason) to transcend particularity and contingency. The ideals presuppose a universal, homogeneous and essential human nature.

In keeping with this epistemological legacy, Luxi (interview 13/10/2000) says that the doctor's task is to assess whether a particular side effect is "really a real" risk. This process is very difficult when faced with patients whose "subjectivity" disturbs access to the 'real'. Luckily, the professed disinterestedness of the doctor and the doctor's "notes" erase the possibility of any emotional/subjective-reason interplay. Luxi deems this the "closest way to get objectivity". The hidden epistemological assumptions underlying Luxi's comments have been exposed as stemming from well-known Western claims about knowledge foundations. The apparently easy feat of transparently representing the "really real" is a false hope. She does not embrace the possibility that there is no immediate, unmediated access to a pre-existing 'reality'. In other words, Luxi is diametrically opposed to the narrator in the poem 'A Window Frame'[16] who realises, finally, that 'reality' is not transparent like a window. Luxi steadfastly believes that the process of "going through the [doctors'] notes" – which have transformed patients' subjectively discerned symptoms – will provide a disembodied account of the "real", 'material' risks associated with OCs.

Luxi's (interview 13/10/2000) consistent presupposition is that patients are incapable of keeping a "diary" or "chart" of their "really real" side effects, but that doctors are able to fulfil this task through their "notes". She clarifies her stance by claiming that "objectivity" is unachievable through patient charts or diaries because "you are asking them to ask themselves if they have any problems". She further states that this system is also "subjective because they are faced with this everyday...searching for an answer, a side effect, an experience". It is worth highlighting that the doctors' "notes" are elevated above "diaries" or "charts" in this hierarchy of 'measured' OC risks. The "notes" are perceived as being endowed with the ability to transcend the subjectivity that saturates patients' own records. The

"notes" – partly because their own subjective assumptions are eclipsed – appear universal, objective, neutral and 'real'.

But are the processes and the assumptions involved in collecting doctors' "notes" very different from the consumers' diary or charting procedures? I would argue that doctors' "notes" are, like diaries, subject to unreliability, subjectivity and "changes". It is not so much the subjectivity of the doctor that is seen as producing the knowledge about OC risks, so much as the objectivity of the scientific method, in this case, the "notes". The method itself relies on the so-called subjective accounts of users. Doctors think that they are 'translating' patients' narratives when they rewrite them as "notes". It is as if the seeming detachment of the figures from embodied, subjective accounts can absolve the numbers from any hint of subjectivity. And yet these numbers cannot exist without embodiment. Frank (1995, p.11) aptly calls this the "colonization of experience". He likens medicalisation to postcolonialism. This is because in both cases the coloniser (doctor, imperial power) refuses to recognise the necessity of the 'other's' inputs in their supposedly objective, superior accounts. Drawing from Spivak, Frank (1995, p.25) elaborates with the observation that the "professional text" – here the doctors' "notes" – *need* subjective embodiment, but that they do not acknowledge that need. Similarly, Luxi (interview 13/10/2000) fails to declare her reliance on the subjectivity of patient "diaries" and admit that her own "notes" are peppered with a collection of subjective narratives from her patients and herself. Subjectivity and objectivity become intermingled. Therefore, contrary to *universal* belief, doctors do rely, necessarily, on subjectivity, "diaries", and "unreliable" descriptions of physiological symptoms.

For many OC users, it is the abstraction of so-called objective and reliable "notes" and figures that is "unreliable". As Sarah (interview 26/9/2000) explains, the abstracted figures presented to her by her general practitioner were meaningless until they were not only interpreted by her doctor, but also embedded within her own personal embodiment:

> I had a blood cholesterol test because of my father's early death...[My doctor] got the graphs out and showed me that these were the protector factors: being female, young and these are the risk factors: smoking, blah, blah, blah. And she showed me my file and lots of it I thought, 'that's me' but some of it was very removed. So I was glad when she showed me what she thought the figures meant. I was really pleased that she had taken the time to do that because not many GPs would bother. Then I went home and I put the numbers in context. I thought about what my body had been doing before the test and so on. And whether the risks would apply to me.

Sarah's (interview 26/9/2000) exposition can be read alongside Luxi's (interview 13/10/2000) remarks. Unlike Luxi, Sarah (interview 26/9/2000) recognises some of her own subjective account about her 'body-self' in her GP's "file" (doctor's "notes"), while at the same time she also finds aspects of this information "very removed". Sarah's recognition of subjectivity in the files is illustrated when she describes reading her "file" and thinking "that's me". Moreover, it is significant that she says her doctor explains what "*she* thought the figures meant" (my emphasis). Sarah does not say that her doctor tells her what the figures 'really' meant. There is an implicit assumption in her remark that figures carry multiple meanings. Indeed, she does not passively take her GP's interpretation of the blood test figures to be the only version. Rather, the numbers are placed in the "context" of her body's history and her own reflections on her corporeality. This contextual situating of numbers is essential because numbers are considered "removed", abstracted from meaning. One way to give them meanings is to piece the different interpretations of figures together which includes *locating* the peculiarly abstracted statistics within the 'body-self's' personal and social context. Sarah does not accept that the 'real' meaning of her body's physiology is encapsulated in the numbers. She even plays down the 'material' risks. This is illustrated through her dismissive "blah, blah, blah" and her questioning of "whether the risks would apply to" her specifically. Sarah is fulfilling the role expected of her as an 'assertive patient' (Cartwright, 1988, p.174). However, unlike Cartwright's ideal consumer, she is not merely seeking 'material' information, but mixing positivistic knowledge with other knowledges. Sarah (interview 26/9/2000) is implicitly questioning the ability of 'official', 'expert' knowledge to maintain its mystique and, more importantly, withstand ruptures from strategies such as bricolage. Conversely, Luxi's (interview 13/10/2000) position is that there is one truth, one knowledge that can be systematically constructed from doctors' notes. The subtext underpinning her quotation is that she thinks if it is not possible to transcend subjectivity and the particularities of its *locations*, then there is no knowledge worth collecting or analysing. Consequently, there is certainly no point asking patients to "chart" their bodily knowledges.

The point of this in-depth analysis of Luxi's (interview 13/10/2000) and Sarah's (interview 26/9/2000) quotations is twofold: first, to highlight the inherent assumptions and secondly, to problematise what is considered a 'material' risk and explore the way that these risks are *made,* or constructed and are not objectively *given* to us by scientists, doctors or the courts. These materialist-positivist approaches construct certain knowledge, and the risks they consider 'material'. For example, Doctor X (interview 14/9/2000) does not consider the potential risk of

thrombosis through use of 3GOCs 'material' or "important" enough to warrant mentioning to consumers. He says that "people hardly ever die from this...it's a very small risk". In his view, the degree of importance of the risk is equated to the possibility of mortality. This type of approach minimises risks. It fails to notice that in addition to the risk of mortality, the risk of 'minor' side effects is also often considered important to users. Moreover, the positivist approach, exemplified by Doctor X, excludes the possibility that other knowledges can also be 'material' and important when making 'informed' decisions within a 'discursive field'[17] (Weedon, 1987) such as contraception. Indeed, many consumers believe that it is *reasonable* to weigh up and assess a seemingly disparate collection of 'material' knowledges. When only the 'material' ('major') risks of a product are disclosed, the corollary is sometimes risky. For example, Judith Sim, a Christchurch NFP teacher who participated in this study (interview 28/8/2000), describes the adverse consequences that can follow when health practitioners fail to disclose 'minor', immaterial risks:

> A client asked the doctor to tell her about *all* the risks with depo provera. She eventually chose it, thinking it was safe, that there were no risks. And all her hair started to fall out. So she went back to the doctor. And in the end the doctor admitted that this was a very rare side effect of depo provera. He hadn't bothered to tell her in the first place because it's statistically small. But she had virtually lost all her hair! And it took her a long time to realise that it was depo that caused it. So, yes, it's difficult to tell people all the information, but I think that it has to be done otherwise you get a side effect but don't know what the cause is. She had been told other risks but not that one. The doctor probably just hoped that she wouldn't get it because there was only a small chance.
>
> (Judith's emphasis)

Despite Judith Sim's (interview 28/8/2000) suggestion that this woman's request that her doctor disclose "*all* the risks with depo provera", the information divulged is based on an epidemiological construction of risk. Like Doctor X (interview 14/9/2000), the possibility that this consumer will experience this rare, "statistically small" side effect is constructed as unlikely and, therefore, the potential risk is not disclosed. This is a typical epidemiological, positivist approach to risk (Gabe, 1995; Gifford, 1986, pp.216-217). Research is used to quantify risk by examining the correlation between a risk factor (for example, being over thirty five and on OCs) and an expected outcome (for example, mortality rate). Such statistical correlation may be evidence of, but is not necessarily 'proof' of causation. Health providers can only translate epidemiological risk measurements into guidelines for deciding what to disclose to 'at risk' consumers. Gifford (1986, pp.220-222) highlights that the shift from an epidemiological to a clinical definition of risk is fraught with difficulties. This process is uncertain because while the

numerical data shows which type of person is more likely to experience a given outcome, it cannot give definitive answers about whether a particular individual will be exposed to the risk. Accordingly, the doctor knows that there is a statistically "small chance" that his 'patient's' hair will fall out, so he chooses not to disclose this potential risk based on the 'evidence'. Herein lies one of the limitations of positivist approaches to risk. However, this construction of risk is considered reasonable and, thus, consumers, such Judith's client above, are judged *unreasonable* if they want to know "all" the risks, even the 'immaterial' ones.

The epidemiological and clinical models of risk also hold that it is *unreasonable* to unveil "all" the risks associated with drugs such as OCs because of their construction of the meaning of 'safe'. Pursuant to positivist frameworks, safety is primarily construed as being relative to something else. By contrast, when some consumers (such as the client Judith describes above) hear that drugs, like depo provera are "safe", they think that this means they are safe in absolute rather than relative terms. These different terms of reference are analogous in an oral contraceptive context. For instance, Djerassi (1979, p.37), who is one of the pill's initial researchers and developers, states that "safe does not mean safe". This is because it is "not possible to develop a pill that does not have side effects" (ibid). Conversely, many OC users have the impression that when a drug is labelled 'safe' it means that they will be free from harm, danger and risks. The depo provera user above (Judith Sim, interview 28/8/2000), for example, suggests that 'safe' means risk free.

Djerassi (pp.36-37) cites a 1970 conversation between Senator Nelson and Dr Edwards in order to highlight the mutable meanings affiliated with 'safe'. When questioned about the assumptions and procedures that go into classifying a drug as 'safe', Dr Edwards concedes that 'safe' only means that it reaches a certain standard set down by the Food and Drug Administration's conditions for labelling (ibid). Furthermore, it does not follow from the categorisation that OCs are 'safe' that they are "innocuous" or free from "contraindications" (ibid). The interpretation of safety from one dimension to another requires fundamental transformations in meanings. For instance, the depo provera user was under the impression that this drug was 'safe' according to the literal meaning of safe, rather than the standards for drug safety that must be met. Given that she suggested depo was 'safe', she did not link depo provera with causation for the hair loss. Moreover, since the former meaning of safe - held by many consumers - is delegitimised in favour of the latter 'official' knowledge, the physical 'reality' of bodily side effects, such as hair loss, remains obscured and in the background. The medical model maintains that the

relative safety of OCs justifies their withholding of 'full' information about possible risks.

The unreasonableness of 'fully' informing consumers is also contended because of the scant evidence that exists to support the definitive existence of 'minor' risks. Given that there is "insufficient evidence to warrant changing to other brands [of OCs]" (Doctor X, interview 14/9/2000; *The Dominion*, 1995, p.3), it is perfectly reasonable to be "convinced that [OCs] are safe" (Doctor X, interview 14/9/2000). Indeed, Dr Jessamine, quoted in *New Zealand Woman's Weekly* (2000, p.20), is likely to re-establish the epidemiological meaning of 'safe' by saying, without qualification, that OCs are "extremely safe". My concern is not with the mutability of meanings associated with 'safe' which seems inevitable. What I am arguing is that it is *risky* and *unreasonable* to invoke such a meaning without qualifying it by making explicit the underlying assumptions: in this case, that "safe does not mean safe" as Djerassi insists. The speakers of these accounts are able to function like the 'modest witnesses' whom Haraway (1997, pp.23-24) describes. The 'modest witness' has the extraordinary capacity for "self-invisibility" (ibid). S/he can eschew the epistemological foundations of a meaning like 'safe'. More importantly, though, the 'modest witness' is able to avoid responsibility for any dire consequences that flow from his/her constructed meanings. The 'modest witness' position is indeed 'safe'. Haraway's (ibid) solution is to propose "situated knowledges" which would locate the "unmarked" speaker and, therefore, ensure that s/he takes responsibility for the ramifications of meanings.

Despite Haraway's critiques of scientific knowledge production, some doctors persist as 'modest witnesses'. For example, Dr Rosemary Reid (interview 31/8/2000) suggests that concealing is often preferable to disclosure. She says that the 3GOC controversy is "misrepresented" and that this is "more harmful than hiding the information...until there is sufficient scientific evidence and scientific appraisal". This is a clear indication that "hiding" is valued. Disclosure must only occur after the 'modest witness' has evaluated the controversy and established the factual evidence. It is only this figure who has the remarkable power to "bear witness: he is objective; he guarantees the clarity and purity of objects" (ibid). It should be made plain that Dr Rosemary Reid is suggesting not that *some* information not be divulged, but that *all* of it should remain hidden until the 'facts' have been surveyed by 'experts'. Some doctors' focus on the insufficiency of existing evidence is inadequate as grounds for "hiding" information. When doctors refer to the lack of evidence to support the case that OCs pose risks to users, their unvoiced assumption is that no evidence exists to "either *confirm* or *deny* the

concern" (Cannold, p.174, her emphasis). The 3GOC controversy should not centre around questions of sufficient medical evidence. My point is that this objective is not a reasonable justification for withholding information in the 'informed consent/choice' process.

The counter argument is that incomplete disclosure of medical information is justifiable because it is an "impossible task" (Doctor X, interview 14/9/2000) to disclose all the potential minor side effects associated with OCs. Other doctors' statements convey analogous dissatisfaction with what they consider an "unrealistic requirement" (Peter Kearns, Co-Director and naturopath CCNM, interview 26/8/2000) and an "annoying standard" (Luxi, Christchurch doctor, interview 13/10/2000). Due to the perceived difficulties in attaining 'informed consent/choice', many health providers choose only to disclose what they deem the 'material' risks. This involves simply providing consumers with a "quantification of the increased risks" (Dr Rosemary Reid, interview 31/8/2000). Reid goes on to claim that such numerical knowledge means that "most women, when they see the figures, will agree with us that there is not a huge risk at all". And, indeed, some OC users do. The perspectives of health providers and users within the 3GOC controversy are not consistently diametrically opposed. On the contrary, there are sometimes overlapping areas. Marion (interview 29/8/2000), for instance, mentions that when she went to her doctor about the potential risks of taking 3GOCs, she left "thinking, oh, what is the big deal?" Her conclusion is partly due to an "examination of the figures which show [her] that the risks are actually quite minimal". Likewise, Heidi (interview 26/8/2000) also utilises a discursive strategy that is generally associated with health providers when she says that after "looking at the stats" and realising that "only one in every thirty thousand people get a clot, then, to [her], that is quite a small chance".

Both Marion (interview 29/8/2000) and Heidi (interview 26/8/2000) invoke a discourse that minimises risk. They rely solely on medical knowledge and the epidemiological model when making their decisions about how to respond during the 3GOC controversy. Based on the statistics, both Heidi and Marion decide to continue taking 3GOCs. Their reasons are indicative of an overlap in consumer and health provider knowledge bases. However, this merging is not recognised in much of the literature that deals with consumer and health practitioner conceptions of risk. The rigid separation between the two groups is generally emphasised (Phillimore & Moffatt, 1994, p.147; Irwin, 1995; Parsons & Atkinson, 1992). Although I concur with this literature that differently positioned people frequently speak divergent discourses, I do not want to suggest that there is a firmly

entrenched separation. The assumptions underlying these two consumers' 'informed choices' indicates that there is sometimes overlap between consumer and health provider assumptions during the 3GOC controversy.

In summary, this chapter has illustrated that most of the OC users interviewed are not 'blind consumers' or 'victims', but proactive health consumers who engage with information in order to make 'informed' decisions. It is my argument that what the health consumers in this study consider to be 'informed' carries a meaning that is different from that encapsulated in the legal precedents pertaining to 'informed consent/choice' and risk. While health providers are legally required to transmit information (and in some situations ensure that consumers sign consent forms), 'informed consent' is much more complicated than these regulatory practices. Consumers do not magically become 'informed' through the disclosure of medical information that the law insists doctors provide. Rather, as this chapter and Chapter Four argue, many of the consumers interviewed in this study construct themselves as 'fully' informed once they have evaluated a compilation of relevant knowledges. It is through engaging in this strategic process that consumers feel that they are proactive and 'fully informed' consumers.

In the next chapter, the discursive 'toolboxes' that differently positioned people draw from are highlighted by exploring the ways that bricolage is a process much like patchwork, or 'weaving', whereby different, often incommensurable, strands of knowledges are pieced together. This concluding chapter illustrates that the practice of bricolage is an ongoing process which requires continual and ongoing 'weaving'.

NOTES

[1] The Cartwright Report is persuasive but not binding (Antonia Fisher, solicitor, interview 11/9/2000). In other words, courts are not bound by the findings but they certainly consider her Honour's recommendations seriously. In addition to the common law, there is relevant legislation pertaining to 'informed consent/choice' which is beyond the scope of this thesis. Collins' (1992) text on medical law in this country provides a thorough treatment of the legislative offspring of the Cartwright Report. Briefly, the doctrine in Aotearoa/New Zealand has not developed at the same rate as other countries because of the effect of the ACC legislation. Section 5(6) of this Act is pertinent. Further, the office of the Health and Disability Commissioner and the *Code of Health and Disability Services Consumers' Rights* owe much to Justice Cartwright for their inception (Cartwright, 1988, p.172). Rights 5, 6, and 7 of this Code interact to form the nucleus of the doctrine of 'informed consent'. Finally, another statute foreshadowed in the *Cartwright Report* is *The New Zealand Bill of Rights Act 1990*. In particular, section 11 guarantees the right to personal autonomy. Finally, also of

considerable importance throughout the Cartwright Report was the 1947 *Nuremberg Code* and the *World Medical Association's Declaration of Helsinki*. The former was enacted after revelations at the Nuremberg Trials of Nazi War Criminals who committed experimental medical atrocities in concentration camps. This formed the basis of subsequent codes such as the latter. The central principles of both Codes are the necessity of 'informed consent' and the duty of the investigator to refrain from harming the 'subjects' (Coney, 1988, p.134; Cartwright, 1988, p.138).

[2] Peter Kearns (Co-Director and naturopath CCNM, interview 26/8/2000) is drawing a distinction in approaches to health between the generation born in the 1970s, including myself, as opposed to those born in the 1940s, which includes him.

[3] Ruth is not only an example of the media's construction of the patient as 'victim', but also an illustration of the ways that patients can resist this positioning. Ruth was the first patient who spoke publicly about the 'unfortunate experiment' and who prompted the investigation.

[4] Encouraging women to actively participate in accessing different sorts of information about health issues and learning about their bodies is not a new idea. For example, in the late 1970s, the Boston Women's Health Collective published a book called *Our Bodies, Ourselves: A Book by and for Women (*1998 revised ed., New York, Simon & Schuster) which was an outcome of resistance to women health consumers as victims. The book put together different sources of information, medical, plus what different women had to say about health topics. This book celebrates bricolage without using the term.

[5] Thanks must go to Sarah Bickerton for both confirming my initial thoughts on Doctor X's (interview 14/9/2000) quotation and also for her additional erudite comments. In particular, she also pointed out that another assumption underlying Doctor X's remarks is that the lesbian 'lifestyle' is wrongly equated with an inability to become pregnant. She questions what he thinks this 'lifestyle' involves. Furthermore, Doctor X's assumption is another attempt to eliminate feminists-lesbians from the 3GOC debate. Given that feminists/lesbians do not get pregnant, then they have no need for OCs and, consequently, they have no place in the debate. Doctor X (interview 14/9/2000) does not suggest that contraception has a very long historical trajectory as a feminist concern.

[6] A 'competent' patient is defined, inter alia, as someone who is not a child or mentally 'ill'. See Collins, 1992, pp. 75-104 for more details about this.

[7] This section traverses some of the relevant case law pertaining to 'informed choice/consent' that was considered during the Cartwright Report. It does not, therefore, provide a full description or analysis of all the common law in this area. Please see Collins (1992) which is a thorough coverage of the pertinent 'informed consent/choice' precedents.

[8] *Salgo v Leland Stanford Uni Board of Trustees* 317 P 2d [1957] (Cal Dis App)

[9] *Smith v Auckland Hospital Board* 191 NZLR (CA) [1965]

[10] *Canterbury v Spence* 464 F 2d 772 DC [1972].

[11] I owe the notion that selves, bodies and nature are 'made' not given to Haraway (1989) and Oudshoorn (1994).

[12] The 'reasonable person' standard has also been criticised for other inherent problems in addition to the ones that are my focus (Greenawalt, 1992, pp.144-148). In particular, opponents of the concept have argued that it is discriminatory. Indeed, one of the original formulations of the test found in the *Hall v Brooklands Auto Racing Club* case (1933, 1 KB 205 CA) held that the "reasonable man [sic] is the man on the Clapham omnibus" (p.224). Pursuant to this case, the 'reasonable *person*' could only be the 'reasonable *man*'. The universal "everywhere but nowhere" (Haraway, 1997) legal subject was male. This is partly

the result of the familiar dualism which constructs women as closer to nature, embodiment and, thus, subjectivity and irrationality; whereas men are deemed to be close to the rational mind. Even when the crucial language did shift from 'man' to 'person', some feminists maintain that this open standard is filled in via a discriminatory process, whereby the referent, although hidden now, remains 'man'. Similar arguments are made regarding the way that this concept also denotes a heterosexual, Western, white 'reasonable person' and does not allow for any difference (Naffine, 1990; Duncan, 1996).

[13] *Rogers v Whittaker* 175 479 CLR [1992]

[14] Personal email correspondence with scientific researcher (5 September 2000).

[15] Although my prediction that some of the doctors would prefer so-called 'objectivity' was often confirmed, this is not to say that my expectations were always correct. On the contrary, my preconceptions were frequently disrupted. Please see Chapter Two for a discussion of these disruptions. Furthermore, the fact that I entered the 'field' with such ideas highlights the inherent problems associated with attempts to conduct 'grounded theory'. I would argue that one 'solution' is to adopt a reflexive approach throughout the research process so that such presuppositions can be interrogated and destabilised.

[16] See Chapter Three where I discuss this poem in more detail and explain its relationship to my theoretical approach throughout this thesis.

[17] A 'discursive field' contains competing meanings and ways of organising procedures and institutions (Weedon, 1987, 35).

CHAPTER 6

THE IMPERATIVE TO '(RE)POLISH' RATHER THAN CONCLUDE

> The cloth of meaning may have to be woven out of a myriad scraps and off cuts, but woven it is, day after day, year after year.
>
> (Worpole, 1990, pp.44-45)

This thesis has focused on a strategy utilised by a number of contraceptive consumers during the 3GOC controversy which involved evaluating multiple sources of information, or a "myriad [of] scraps", which were refashioned as part of a process that I have interpreted as bricolage. This is the process Zena has referred to as continual "polishing" through talking and information gathering. I have not argued that this process provides neatly "woven" solutions. Rather, I have illustrated the ways that bricolage in action is an inherently 'messy' (Denzin, 1997, pp.xvi-xvii) process.

The purpose of this chapter is not to provide definitive conclusions about the 3GOC controversy, but to highlight the ongoing process, identified by Zena, of '(re)polishing' issues surrounding contraception "day after day, year after year". One contraceptive consumer, Emily, highlights the necessity of continuing to make sense of the "issues" surrounding contraception. She contends that, although she "could honestly say that the medics think that there is no debate now... for us, the ones who have to use contraceptives, it's never over. We have to keep working out all the issues for as long as we want to prevent pregnancy." Similarly, as I canvassed in Chapter Three, the strategy of keeping a 'scrapbook' with a compilation of bits and pieces of information which are retained on the principle that they "may always come in handy" (Lévi-Strauss, 1968, p. 18), also indicates the imperative to '(re)polish' rather than conclude. The metaphor of a woven cloth, patchwork or web captures the ways that many of the consumers interviewed for this study reworked and '(re)polished' various disparate, and often incommensurable, knowledges in order to make sense of the controversy. Just as patchwork, weaving and webs can connote imagery of different "scraps" and "off cuts" pieced and woven together, the process of bricolage also involves recombining strands from the discursive 'toolbox' which have often been "transmitted in advance" (Lévi-Strauss, 1968, p. 20).

My primary focus has been to explore the meanings associated with such discursive "off cuts" that had been circulating for some time. For example, in Chapter Five I illustrated that meanings associated with the perceived 'safety' of OCs are highly variable. Similarly, the discursive 'toolbox' connected to risks associated with OCs was explored in Chapters Five and Three, but especially Chapter Four,

and 'informed consent/choice' was troubled by illustrating that its meanings are not as neat and tightly woven as its legal definition suggests.

The emphasis in this research and in the thesis has not been on solving, proving, or assessing the medical evidence or resolving the physiological debate surrounding thrombosis and 3GOCs. My concern was to explore some of the meanings, discursive strategies and 'storytelling' that circulated during the controversy. Despite some commentators' insistence that, for instance, the 3GOC controversy was solely concerned with "one aspect of pill use: thrombosis" (Doctor X), this thesis provides insight into the multiplicity and proliferation of discursive strategies circulating before and during the controversy. Instead of being interested in whether or not certain medical 'facts' associated with OCs are true, my concern was to illustrate the function(s) of discourses by enquiring into the epistemological and ontological agendas and assumptions which are often hidden under the guise of 'objectivity', 'factual' knowledge and 'reality'.

My theoretical approach throughout the thesis drew heavily from the idea that 'reality' is a problematic notion (Butler, 1992; Walby, 1992; Davies, 1992; Davies, 1997). This was developed in Chapter Three and illustrated partly by Curnow's (1974, p. 63) poem "A Window Frame". Curnow's narrator realises that language refuses to perform the function of access to the 'real'. He is forced to realise that 'reality' is not like a transparent window, innocently framing what is outside. Rather, the narrator is involved in the framing of 'reality' outside the window. This thesis has called into question the assumption that language is a representational, referential system that innocently reflects 'reality'. For example, in Chapters Three and Four, I probed statistical formulations that circulated during the 3GOC controversy by suggesting that they are rule governed, constructed meanings that are sometimes developed in an endeavour to be neutral and to appear as if there is no meaning being applied to an event.

Some poststructuralist ideas hold that what we refer to as 'reality' is constructed through discourse (Butler, 1992; Walby, 1992; Davies, 1992; Davies, 1997). In this sense, the 'reality' *is*, or *becomes* the meanings that are constructed. This is not to say that there is no 'reality' and that the entire world is reduced to discourse, but to point out that the representation of that 'reality' is a construction of meanings (Jones, 1997; Davies, 1992; Davies, 1997; Butler, 1992; Singer, 1992; Flax, 1992). During the research process (and in Chapter Four) I grappled with the supposed material, discursive divide. I asked ontological questions about being, what exists and what is. Specifically, I was anxious about diminishing and

invalidating consumers' 'experiences' of pain associated with OCs by reducing their symptoms to mere discursive constructions. I asked what it meant when consumers made adamant statements such as Jacqueline's assertion that "there *is* pain in [her] leg that's got something to do with the pill". My interest in discourse does not involve assuming the view that bodily pain does not 'exist', but it does involve attention to the discursive meanings that people attach to embodiment. This is vital because meanings are discursively apprehended. The same physical sign (a headache, for example) is often associated with differing meanings which are utilised to explain and articulate pain (Williams & Bendelow, 1998, pp.155-157). By paying attention to these contrasting meanings attached to embodiment, the way that material (bodies) are mediated through the discursive becomes clear (Shildrick, 1997; Usher, 1997; Shildrich & Price, 1996).

In other words, it is constructed meanings that frame what is referred to as 'reality'. According to Ackerman (1990, p.301), it is difficult, if not impossible, to "leave the palace of our perceptions". Not only did I subscribe to this type of stance regarding my theoretical approach throughout the thesis, but I also adopted it when formulating my methodology. For instance, the 'storytelling' generated by the participants in this study was conceptualised not as accounts of what 'really' happened, but stories about what 'actually' (Denning, 1994) occurred. Denning uses the terms 'really' and 'actually' in order to demarcate between realism and acting, performance and construction. He argues that what really happened, or the so-called 'real' story, can never be discovered because we can only ever know what actually occurred, or a version of 'reality'. Denning argues that the illusion of realism needs to be negated by paying attention to innumerable cultural constructions and the performance of what 'actually' happened. According to this formulation, the interviewees' narratives consist of a layered "myriad" of (re)workings, (re)memberings and '(re)polishing[s]'.

A further aspect of this ontological position is that any meaning that a person brings to an 'experience' depends on the discursive resources that are available and, thus, it is open to the re-construction and the co-construction of stories by both the interviewee and researcher. As I illustrated in Chapters Three and Four, many of this study's participants 'made do' with the discursive possibilities readily 'at hand', such as choice, feminism and consumer rights. Although my interviews with contraceptive consumers were not extensive or statistically representative, the majority of participants, through picking up discourses and through the meaning-making processes, constituted their subjectivities.

The consumers' subjectivities are primarily discursively constituted. The ways that they make meanings related to the controversy and how they make sense of their bodies is inextricably connected to discourses that they take up as their own. It is hardly surprising, then, that some consumers interviewed explained their decision-making processes by referring to their perceived 'real' identities. For example, it was not uncommon for some OC users, such as Marion, to speak about the "real me" as an explanation for her actions during the 3GOC controversy. I argued that when a consumer constitutes herself through a certain discourse then it appears that she is not being 'real', authentic, or 'true' to herself if she fails to be consistent with this discursive strategy. My point is that the *realism* of *appearances* becomes convincing.

Certain 'facts' and knowledge also appeared to be 'real' during the controversy. For example, statistical and 'material' risks associated with the pill were 'blackboxed'. Consequently, they appeared to be settled, "secure" (Doctor X), natural and essential. In Chapter Three, I explored how the deaths of some women in Aotearoa/New Zealand who had been taking 3GOCs 'opened' some 'blackboxes' associated with this medical issue for debate. Prior to this contraceptive controversy, it seemed that 3GOCs were not risky because the safety of this formulation was presumed to be 'blackboxed': settled, a well-established 'fact' which was immutable and durable across time and space. During the debate, many of the 'experts' (medical professionals and government handouts) tried to re-box 'facts' about OCs in order to convince users that it was appropriate to continue taking the pill. For example, in addition to Doctor X's comment that the data was "secure", Doctor Rosemary Reid espoused similar rhetoric when she said that the statistics pertaining to mortality and 3GOCs were "solid". The problem-solving technique here is to rearrange the statistical 'blackboxes' into an appropriate pattern by reshuffling, but without actually 'opening' them for further scrutiny. In addition to the statistical blackboxes that are reinstated by some of the medical professionals interviewed, I also trouble what gets stabilised as constituting 'informed consent/choice' in a medical encounter in Chapter Five.

The common law pertaining to 'informed consent/choice', explored in Chapter Five, also contributes to the supposedly 'real' and natural understanding that the subject is singular, autonomous, rational: the 'reasonable person'. Chapter Five explored the assumptions underneath this conceptualisation in order to illustrate that the invisibility of such epistemologies gives this knowledge the appearance of being more 'natural', right, unquestionable and infallible. Although the law holds that a person is 'fully' informed when s/he has had the 'material'

(read: factual, medical) knowledge disclosed to her/him, this thesis argues that many consumers only construct themselves as 'informed' when they have drawn from a variety of medical and extra-medical discursive approaches. It is also important that they make the connections between the 'material' and 'expert' information and their experience of bodily sensations, pain, dis-ease and wellbeing.

Conversations with the contraceptive consumers who participated in this study indicated that many of them actively 'took up' the discursive possibility articulated by Silvia Cartwright that patients behave assertively in health care encounters. This was illustrated by the resistance to 'blind' consumers and 'victim' positions espoused by some of the consumers interviewed, such as Ellen and Emily. Although this thesis has focused on consumers who constitute themselves as people who proactively 'pick up' information in order to make sense of medical controversies, not all consumers construct themselves in these terms. Indeed, as I outlined in Chapter Four, while most of those I interviewed adopted this process, not all the consumers in this study used bricolage during the 3GOC controversy.

This difference in problem-solving strategies when faced with a medical controversy highlights one of the limitations of this study. While this thesis focuses on a strategic response to a medical controversy that I refer to as 'bricolage', I recognise that this primary focus eschews alternative responses that participants might adopt in response to a medical debate. I only spoke to a limited number of people that I contacted through a specific range of contexts. The notices inviting participation attracted people who were primarily assertive and had a lot of energy for accessing information about the controversy from a variety of sources and discussing the issues. Many of the consumers interviewed, but not all of them, deploy the 'bricolage' strategy. There are also differences among participants in the tactics they utilised to gather and combine information. There are many other possible strategies that can be invoked during a medical controversy. Apart from the cursory analysis of such approaches in Chapter Four, these aspects were either not covered in depth or were beyond the scope of this thesis. Further empirical research into the variable range of strategic responses to medical controversies would provide a more comprehensive analysis of the ways that people respond to medical debates.

In part, I tried to acknowledge the multiplicity of approaches to a medical debate by recognising that bricolage and 'blackboxing' are not the only possible strategic responses to the 3GOC controversy. This was primarily demonstrated in Chapter Two by suggesting that there is not a strict demarcation between blackboxing and bricolage, and, in fact, that bricolage can even include 'blackboxed'

information. I also pointed out in Chapter Five the limitations of bricolage, partly, in an attempt to show that this process is not always the most appropriate for all differently positioned people and certain circumstances. Since bricolage involves working laterally, skimming the surfaces or information sources in order to make decisions, rather than delving deeply, this tactic is not necessarily appropriate for contraceptive researchers, for example. The point is that bricolage and blackboxing are not the only possible strategic responses to a medical controversy and it would be interesting for future research to concern itself with the multiplicity of processes and dynamics at work during a medical controversy.

Research into the multiplicity of processes in action during a contraceptive controversy could involve applying what I referred to in Chapter Three as a 'whiteboxing' methodology. Borrowing from software engineers' use of 'white box testing', I have invoked the term 'whiteboxing'. The purpose of this notion was twofold. First, this term requires attention to processes and dynamics by investigating blackboxes that pertain to internal workings and complexities (rather than simply inputs and outputs). Secondly, I described one of my tasks as a researcher to engage in 'whiteboxing'. This meant that I selected certain 'boxes' to explore such as those that pertained to knowledge, information and meaning constructions and appropriations. While my initial aim was to engage in 'whiteboxing', as the research progressed the complexity and detail required to thoroughly investigate the internal workings of blackboxes relevant to the 3GOC controversy meant that what I did, in the end, was a mutated version of 'whiteboxing'. However, the conceptual possibility of undertaking 'whiteboxing' allowed me to recognise the importance of re-examining the intricacies and complexities of meanings circulating during a medical controversy.

Paying attention to some of the processes and strategies, such as bricolage, invoked by the participants in this study during a medical controversy, also highlighted that responses to debates are complex interventions rather than opportunities for one type of action or another. For example, many of the consumers interviewed did not base their responses to the controversy on *either* medical knowledge *or* 'other' information. Instead, they took action based on a 'both-and' schema which included a (re)combination of various discursive and embodied knowledges. This thesis has tried to resist reinstating dualistic thinking. By using examples, such as the doctor in Chapter Four who drew from her own embodied experiences of diaphragms and statistical data, I have troubled binaries which posit health providers' and consumers' responses to medical debates at opposite ends of the continuum. This example, in addition to examples of consumers in this study

who invoke various discursive strands, unsettle thinking that rigidly places health professionals as 'experts' who only utilise objective medical knowledge and consumers as the lay 'victims', using subjective understandings of health issues such as risk.

Throughout this thesis the contraceptive consumers who participated in this study engage actively in critical commentary on 'expert' information sources. This sort of interaction during a medical controversy, in combination with attention to the specificity of bodily signs, ensures that as consumers they are 'informed' rather than 'blind'. Much of the frameworks of understandings used by 'experts' during the 3GOC controversy centred around the statistical chance and frequency of the risk of thrombosis to OC users. Some of the medical professionals' responses to the debate also focussed on placing the risk of thrombosis in a relative relationship to the risk of pregnancy. These 'expert' responses were illustrated in Chapter Four through an exploration of the government handouts pertaining to 'blood clots' and 3GOCs which were distributed during the controversy.

Many of this study's consumer participants constructed an alternative framing of the 3GOC controversy which accessed 'expert' information, such as statistics, but critically framed these 'facts' by grounding them in relation to how their bodies reacted to pharmaceuticals. The consumers interviewed utilised discursive resources already available to them. They are not outside discourse, rather, they are discursively constituted (Jones, 1997; Davies, 1997). Through picking up certain discursive strands and through the meaning-making process, these consumers are able to constitute their subjectivities so that they are not dupes of 'experts' or pharmaceutical companies.

By utilising the tools 'at hand', the consumers in this study generate new forms of understandings for themselves. They create new knowledges based on the specifics of their own embodied signs, which then provide new frameworks for decisions about contraceptive use that enable them to "move forward", as Zena puts it. The consumers in this study are active theorists who do not merely piece together disparate pieces from the toolbox, but who engage with knowledge in use: practical formulations of information that are based on their own personal biographies and physicality, generating new understandings specific to themselves.

Partially, the consumers who participated in this research are a product of the issues that I valorised. As Cotterill (1992, p.604) points out, in the end, it is the researcher who has "control and power" over the material because it is s/he "who

eventually walks away" and begins to work on the final account. Furthermore, the "responsibility for how the data is analysed and interpreted is entirely" (Cotterill, 1992, p.604) the researcher's. Researchers are "data *creating* social beings" (Ribbens, 1989, p.592) and I acknowledge my analytical presence within the accounts of this study's participants. Given that the 'talk' of this study's participants is a result of co-creation, there is always room for additional perspectives, approaches and research.

Importantly, there is a general need for additional research into contraceptive controversies, and contraception in general, because a number of consumers interviewed, such as Emily, indicated not only the "importance" of accessing contraceptive information, but also the ongoing importance of analysing contraceptive issues. Furthermore, much of the 'talk' surrounding OCs indicated that the amount and type of information that is deemed pertinent by some health providers and statutory regulators is inadequate, in part, because it fails to include a "myriad" of knowledges, including embodied strategies for making sense of medical controversies. The contrast between the law's approach to problem-solving in the medical encounter and the strategy utilised by many consumers in this study (where they "put all [the information] together"), indicates that further research is required to suggest changes in the direction of policy decisions surrounding such issues.

Despite the contrast between medical, legal and consumer approaches to the 3GOC controversy traced in this thesis, I have also pointed out that there are not simply differences in discourses utilised and strategies invoked, but also connectivity. For example, I provided examples of consumers who drew from similar positivist discourses as health providers and a doctor who invoked embodied 'experiences' when advising a consumer about using diaphragms.

Similarly, in addition to choice, feminism and rights, the interview transcripts also highlight the ubiquity of 'talk' about 'natural' and 'unnatural' contraceptives by both health providers and consumers. For instance, Peter Kearns (a Christchurch naturopath and Co-Director of CCNM) claims that 'natural' is "misleading in that synthetic drugs use natural hormones... The labs isolate the biologically active materials and synthesise it in the laboratory". Likewise, Janet, an OC user, also problematises the commonsensical understandings of the definition of 'natural' when she says that "people perceive that natural is much better... but we are easily duped about what is natural... A natural formulation often has the active ingredient in it... Pharmaceutical companies are always trying to make their products more like the natural hormones because people think it's better and will

buy more". There is the potential for future research into OCs, and other contraceptive technologies, to ask questions about why people conceptualise certain methods as 'natural' or 'unnatural'. What discursive strategies are invoked when consumers make statements that they have "real periods" (Heidi) when they are not on the pill. What are the meanings that differently positioned people bring to 'unnatural' and 'natural' as it relates to contraceptives?

It would also be useful to conduct further research which recognises the pill, itself, as having the ability to shape people's perceptions about whether, for example, they are 'natural', 'real' and 'authentic' based on their choice of contraceptive methods. I am suggesting that the 3GOC controversy could also be analysed using Actor Network Theory (Latour, 1987; Latour, 1999; Callon & Law, 1997; Law & Hassard, 1999) as the primary theoretical orientation. Utilisation of this framework would explore, among other things, the possibility that the pill, itself, is a powerful actor that constructs bodies and is involved in the crafting of subjectivities. Due to my focus on the discursive toolboxes, meanings and consumers' responses to the 3GOC controversy, I did not explore fully how the 3GOC controversy might be analysed using an ANT approach. Further research using this theoretical orientation would recognise the pill and media as significant actors within the controversy. Issues relating to Pharmac's decisions to subsidise particular formulations of oral contraceptives would also be an important field of investigation here.

This thesis, albeit briefly, has traced some of the ways in which the media constructed various subjectivities, such as 'victims' and 'experts', during the 3GOC controversy. For example, in Chapter Five, I looked at the construction of the contraceptive consumer as victim by, in part, analysing how this figure was represented in the mass media during the 3GOC controversy and preceding the Cartwright Report. However, it would be productive for future work to provide an analysis of the media's treatment of the 3GOC controversy.[1] This type of analysis could include an exploration of consumers' sense of "frustration" (Sarah) and "annoyance" (Phillipa) that they were dealing with information that had been "transmitted in advance" (Lévi-Strauss, 1968, p.20) to groups of professionals and the media and that they, as consumers, only got to access it well after the actual event.

This study is based on conversations with a small number of people who cannot 'represent' all OC users in Christchurch let alone Aotearoa/New Zealand. Clearly, the interviewees are not a statistically representative group of people, but

the thesis provides a sense of how predominantly active consumers negotiate a medical controversy. The research illustrates some of the possible ways of responding to a medical controversy, which I have identified under the framework of bricolage. A different study accessing a wider range of women would provide varying information.[2]

There are three additional limitations in the research process of this thesis which would benefit from further work. First, this study focussed primarily on people who were 'European', middle class, well educated and employed (as many described themselves in the demographic forms distributed in each interview). Future work would benefit from inclusion of wahine Maori strategic responses to contraceptive controversies. Secondly, although I did not only interview contraceptive consumers, the analysis itself was strongly focussed on their strategic responses rather than those of the state, drug companies, health providers and scientists. Thirdly, as one OC user, Ellen, pointed out, it would be useful to conduct further research in order to investigate "how males see the [3GOC controversy] as well in terms of their experiences of being with partners on the pill during the scare".

This testimony to the involvement of differently positioned people who bring various discursive tools to the debate, is but one example of the ways that a medical controversy is rarely just about the issue at hand: in this case, the risk of thrombosis to those on 3GOCs during the 3GOC controversy. Any medical controversy is likely to be set within a web of discursive strategies and a multiplicity of meanings that are continually being 'woven' and '(re)polished'. In Emily's words, it is important to continue the process of 'polishing' and 'weaving', even after a medical controversy, because contraception is a

> really huge part of every woman's life. And it should be treated as such. This [controversy], for me and my friends, is not just about the third generation pill but about *the* pill. Women have been talking about it for years and we'll keep talking about it even if the medical profession say that the 'case is closed'.

It is important to note that, although many of this study's participants focussed on issues other than thrombosis, that particular medical threat and risk was the basis for their concerns about this pharmaceutical and, thus, the starting point for the controversy and their 'talk' about related, broader contraceptive issues. Even though the epidemiological evidence *appears* to be neatly 'blackboxed' (indicating that 3GOC usage is not directly linked to thrombosis), much of the consumers' 'talk' in this study illustrates that the *'real'* basis for many consumers' action is not the definitive 'expert' statements, or the documentation of statistical risk. Rather, the primary basis for responding to a medical controversy and the

strategy utilised by this study's consumers is an ongoing process of 'weaving' information sources: the process of constant bricolage. This thesis has attempted to document this 'messy' but vital process. Further research is needed to explore how widespread this strategy is and the specifics of its utilisation in the context of other medical controversies.

NOTES

[1] See appendix 8 for a summary of the media's treatment of the 3GOC controversy.

[2] It would be difficult to generate a sample for this type of project because there is not a reliable list of all women in Christchurch or Aotearoa/New Zealand who are on 3GOCs, or even OCs in general.

REFERENCES

Abraham, J. 1994, 'Bias in Science and Medical Knowledge: The Opren Controversy', *Sociology*, vol. 28, no. 3, pp. 717-736.

Ackerman, D. 1990, *Natural History of the Senses*, Vintage Books, New York.

Aggett, M. 1997, 'Anatomy of a Decision – Pills Under Scrutiny', *New Zealand Doctor*, 25 June, pp.19-20.

Arksey, H. 1994, 'Expert and Lay Participation in the Construction of Medical Knowledge', *Sociology of Health and Illness*, vol. 16, no. 4, pp. 448-468.

Atkinson, P. 1989, 'Goffman's Poetics', *Human Studies*, vol. 12, no.1-2, pp.59-76.

Atwood, M. 1972, *Survival: A Thematic Guide to Canadian Literature*, Anansi, Toronto.

Awatere, D. 1984, *Maori Sovereignty*, Broadsheet, Auckland.

Barrett, M. 1992, 'Words and Things: Materialism and Method in Contemporary Feminist Analysis', in *Destabilising Theory: Contemporary Feminist Debates*, M. Barrett & A. Phillips (eds) Polity Press, Cambridge.

Barthes, R. (trans. Heath, S) 1977, *Image, Music, Text*, Hill & Wong, New York.

Baudrillard, J. 1968, *Le Sysème des Objets*, Denoel-Gonthier, Paris.

Baudrillard, J. 1970, *Société de Consummation*, Gallimard, Paris.

Beatson, P & D. 1994 'The Material Infrastructure', in *The Arts in Aotearoa New Zealand*, Massey University, Palmerston North.

Beck, U. 1992, *Risk Society: Towards a New Modernity*, Sage, London.

Becker, H. S. 1998, *Tricks of the Trade: How to Think About Research While You're Doing it*, The University of Chicago Press, Chicago and London.

Beizer, B. 1995, *Black-Box Testing: Techniques for Functional Testing of Software Systems*, Wiley, New York.

Blackbox Testing and Whitebox Testing, [Online], Available: http://www.student.math.uwaterloo.ca/cs241/a/1/blackbox.html

Bloemenkamp, K., Rosendaal, F., Helmerhorst, F., Buller, H. & Vandenbroucke, J. 1995, 'Enhancement by Factor V Leiden Mutation of risk of Deep-Vein Thrombosis Associated with Oral Contraceptives Containing a Third-Generation Progestagen', *Lancet*, vol. 346, pp. 1097-1101.

Bloom, A. 1987, *The Closing of the American Mind*, Dordrecht, D. Reidel, Holland.

Bloom, L. R. 1998, *Under the Sign of Hope: Feminist Methodology and Narrative Interpretation*, University of New York Press, Albany.

Bordo, S. 1993, *Unbearable Weight: Feminism, Western Culture and the Body*, University of California Press, Berkeley.

Boston Women's Health Collective, 1998, *Our Bodies, Ourselves: A Book By and For*

Women, Simon & Schuster, New York.

Bunkle, P. 1992, 'Withdrawal of the Copper 7: The Regulatory Framework and the Politics of Population Control', in *For Health or Profit? Medicine, the Pharmaceutical Industry, and the State in New Zealand*, P. Davies (ed) Oxford University Press, Oxford.

Butler, J. 1992, 'Contingent Foundations: Feminism and the Question of "Postmodernism"', in J. Butler & J. W. Scott (eds) *Feminists Theorize the Political*, Routledge, New York, London.

Callon, M. & Law, J. 1997, 'After the individual and Society: Lessons on Collectivity from Science, Technology and Society, *The Canadian Journal of Sociology*, vol. 22, no. 2, pp. 165-182.

Cannold, L. 1997, ' "There is no evidence to Suggest...": Changing the Way we Judge Information for Disclosure in the Informed Consent Process', *Hypatia*, vol.12, no.2, pp.165-184.

Carnall, D., Karcher, H., Sheldon, T., Lie, L., Spurgeon, D. & Josefson, D., 1995, 'Third Generation Oral Contraceptives – The Controversy', *British Medical Journal*, vol.311, pp.1589-1590.

Cartwright, S. 1988, *The Report on the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into other Related Matters*, Government Printing Office, Auckland.

Castel, R. 1991, 'From Dangerousness to Risk', in *The Foucault Effect: Studies in Governmentality*, (eds) G. Burchell & P. Miller, University of Chicago Press, Chicago.

Collins, D. 1992, *Medical Law in New Zealand*, Brooker and Friend Ltd, Wellington.

Coney, S. 1987, 'Behind the News: The Pill/The IUD', *Broadsheet: New Zealand's Feminist Magazine*, March, pp. 6-7.

Coney, S. & Bunkle, P. 1987, 'An Unfortunate Experiment At National Women's' *Metro*, vol. 7., no. 72., pp. 46-68.

Coney, S. 1988, *The Unfortunate Experiment*, Penguin, Auckland.

Cook, J. A. & Fonow, M. M. 1986, 'Knowledge and Women's Interests: Issues of Epistemology and Methodology', *Sociological Inquiry*, vol. 56, no.1, pp.2-29.

Cotterill, P. 1992, 'Interviewing Women: Issues of Friendship, Vulnerability and Power', *Women's Studies Int. Forum*, vol. 15, nos. 5/6, pp.593-606.

Coulter, A. 1985, 'Decision-Making and the Pill: The Consumer's View', *The British Journal of Family Planning*, vol. 11, pp. 98-103.

Curnow, A. 1974, *Collected Poems 1933-1973*, Reed, Wellington.

Daly, M. 1978, *Gyn/Ecology: The Metaethics of Radical Feminism*, Beacon Press, Boston.

Darling-Wolf, F. 1997, 'Framing the Breast Implant Controversy: A Feminist Critique', *Journal of Communication Inquiry*, vol. 21, no. 1, pp. 77-97.

Davies, B. 1992, 'Women's Subjectivity and Feminist Stories', in *Investigating*

Subjectivity:Research on Lived Experience, (eds) C. Ellis & M. G. Flaherty, Sage, London, New Delhi, Newbury Park.

Davies, B. 1997, 'The Subject of Post-structuralism: A Reply to Alison Jones', *Gender and Education*, vol. 9, no.3, pp.271-283.

Davis, P. 1992, *For Health of Profit? Medicine, The Pharmaceutical Industry, and the State in New Zealand*, Oxford University Press, Oxford.

Denning, G. 1994, 'The Theatricality of Being Observed: Eighteenth-Century Europe "Discovers" the ? Century Pacific', in *Implicit Understandings: Observing, Reporting, and Reflecting on the Encounters Between Europeans and Other Peoples in the Early Modern Era*, (ed) S. B. Schwartz, Cambridge University Press, Cambridge.

Denzin, N. K. & Lincoln, Y. S. (eds) 1994, *Handbook of Qualitative Research*, Sage, London.

Denzin, N. K. 1997, *Interpretive Ethnography: Ethnographic Practices for the 21st Century*, Sage, Thousand Oaks, CA.

Derrida, J. 1976, *Of Grammatology*, Johns Hopkins University Press, Baltimore.

Derrida, J. & Caputo, J. P. 1997, *Deconstruction in a Nutshell: A Conversation with Jacques Derrida*, Fordham University press, New York.

Djerassi, C. 1979, *The Politics of Contraception*, W. W. Norton and Company, New York and London.

Douglas, M. 1990, 'Risk as a Forensic Resource', *Daedalus*, vol.119, no.4, pp.1-16.

Douglas, M. 1992, *Risk and Blame: Essays in Cultural Theory*, Routledge, London.

Dreyfus, H.& Rabinow, P. (eds) 1982, *M. Foucault: Beyond Structuralism and Hermeneutics*, University of Chicago, Chicago.

Du Bois, W.E.B. 1969, *The Souls of Black Folk*, Signet, New York.

Dugdale, A. 1999, 'Materiality: Juggling Sameness and Difference', in *Actor Network Theory and After*, (eds) J. Law & J. Hassard, Blackwell, Oxford, pp. 113-135.

Duncan, S. 1996, 'The Mirror Tells the Tale: Constructions of Gender in Criminal Law', in *Feminist Perspectives in the Foundational Subjects of Law*, (ed) A Bottomley, Cavendish Publishing, London, pp. 173-89.

Du Plessis, R., Higgins, J. & Mortlock, B. 2000, 'Narratives, Community Organisations and Pedagogy', Unpublished paper presented at ISA Biography and Society Conference, Tavistock Centre, London.

Edwards, R. G. & Cohen, J. (eds) 2000, *Human Reproduction Update. Reproductive Choices in 2000: The Relative Safety of Current Oral Contraceptives*, vol.5, no.6, November/December 1999, Oxford University Press, Oxford.

Egermayer, P. & Roke, C. 2000, 'OCs and the Risk of Thrombosis', *New Ethicals Journal*, January, pp. 49-55.

Farmer, R., Newson, R., MacRae, K., Lawrenson, R. & Tyrer, F. 1997, 'Mortality from Venous Thromboembolism Among Young Women in Europe: No Evidence for any Effect of Third Generation Oral Contraceptives, *Journal of Epidemiology*

and Community Health, vol. 51, pp. 630-635.

Firestone, S. 1973, *The Dialectic of Sex – A Case for Feminist Revolution*, Paladin, Herts, St Alban.

Flax, J. 1992, 'The End of Innocence', in *Feminists Theorize the Political*, (eds) J. Butler & J. W. Scott, Routledge, New York and London.

Flax, J. 1993, *Disputed Subjects: Essays on Psychoanalysis, Politics and Philosophy*, Routledge, New York and London.

Fleming, D. 2000, 'Could Taking the Pill Kill?', *New Zealand Woman's Weekly*, 3 July, pp.20. 21.

Foucault, M. (trans. Sheridan, A) 1972, *The Archaeology of Knowledge*, Pantheon Books, New York.

Foucault, M. 1988, *Politics, Philosophy, Culture: Interviews and Other Writings 1977 1984*, (ed) L. D. Kritzman, Routledge, New York and London.

Foucault, M. (trans. Sheridan, A) 1977, *Discipline and Punish: The Birth of the Prison*, Vintage Books, New York.

Foucualt, M. (trans. Sawyer, L) 1982, 'The Subject and Power', in *Beyond Structuralism and Hermeneutics*, (eds) H. L. Dreyfuss and P. Rabinow, Harvester Press, Brighton.

Foucault, M. 1988, *Technologies of the Self*, (eds) L. H. Martin, H. Gutman & P. H. Hutton, University of Massachusetts Press, Amherst.

Foucault, M. (trans. Hurley, R) 1990, *The History of Sexuality, Volume One: An Introduction*, Vintage, New York.

Foucault, M. 1991, 'Governmentality', in *The Foucault Effect: Studies in Governmentality*, (eds) G. Burchell & P. Miller, University of Chicago Press, Chicago.

Frances, R. 1995, 'Experts Consider Risks of the Pill', *The Dominion*, 25 October, p.3.

Frank, A. W. 1995, *The Wounded Storyteller: Body, Illness, and Ethics*, University of Chicago Press, Chicago and London.

Gabe, J. 1995, *Medicine, Health and Risk: Sociological Approaches*, Blackwell, Cambridge.

Gabe, J. & Bury, M. 1996, 'Risking Tranquillizer Use: Cultural and Lay Dimensions', in *Modern Medicine: Lay Perspectives and Experiences*, (eds) S. J. Williams & M. Calnan, UCL Press, London.

Gavey, N. 1989, 'Feminist Poststructuralism and Discourse Analysis: Contributions to Feminist Psychology', *Psychology of Women Quarterly*, vol.13, no.4, pp.459-475.

Geertz, C. 1973, *The Interpretation of Cultures: Selected Essays*, Basic Books, New York.

Giddens, A. 1990, *The Consequences of Modernity*, Polity Press, Cambridge.

Gieryn, T. 1983, 'Boundary Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Identities of Scientists', *American Sociological Review*, vol.48., pp. 781-795.

Gieryn, T. 1994, 'Boundaries of Science', in *Handbook of Science, Technology, and Society*, (eds) S. Jasanoff, G. Markle, J. Peterson & T. Pinch, Sage, California.

Gifford, S. 1986, 'The Meaning of Lumps: A Case Study of the Ambiguities of Risk', in *Anthropology and Epidemiology: Interdisciplinary Approaches to the Study of Health and Disease*, (eds) C. R. James, R. Stall & S. Gifford, Dordrecht, D Reidel.

Glaser, B. & Strauss, A. 1967, *The Discovery of Grounded Theory*, Aldine, Chicago.

Grace, P. 1998, *Baby No-Eyes*, Penguin, Auckland.

Graham, B. T. A. 1995, 'Riding Someone Else's Waka: Academic Theory and Tribal Identity', *Meridian*, vol. 14, no. 2, pp.45-63.

Grant, E. 1985, *The Bitter Pill: How Safe is the Perfect Contraceptive?*, Elm Tree Books, Great Britain.

Greaves, M. & Tabener, D. 1996, 'Thrombotic Disease', in *Oxford Textbook of Medicine*, Oxford University Press, Oxford.

Greenawalt, K. 1992, *Law and Objectivity*, Oxford University Press, New York, Oxford.

Greenlaw, L. 1997, *A World Where News Travelled Slowly*, Faber & Faber, London.

Griffiths, M. 1995, *Feminisms and the Self: The Web of Identity*, Routledge, London and New York.

Grimes, D. A. 1990, 'Breast Cancer, The Pill and the Press', in *Oral Contraceptives and Breast Cancer: The Implications of the Present Findings for Informed Consent and Informed Choice*, (ed) R. D. Mann, Parthenon Publishing Group, Carnforth.

Hall, S. 1990, 'The Emergence of Cultural Studies and the Crisis of the Humanities', *October*, vol. 53, pp.11-23.

Hammersley, M. 1999, 'Not Bricolage but Boatbuilding: Exploring two Metaphors for Thinking About Ethnography', *Journal of Contemporary Ethnography*, vol. 28, no. 5, pp.574-585.

Haraway, D. 1989, 'The Biopolitics of Postmodern Bodies: Determinations of Self in Immune System Discourse', *Differences*, vol. 1., pp. 3-43.

Haraway, D. 1991, *Simians, Cyborgs and Women: The Reinvention of Nature*, Routledge, New York.

Haraway, D. 1997, *Modest Witness @ Second Millennium. FemaleMan Meets Oncomouse: Feminism and Technoscience*, Routledge, New York.

Harding, S. 1983, *Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics,Methodology and Philosophy of Science*, Simon & Schuster, New York.

Harding, S. 1987, 'Is there a Feminist Method?', in *Feminism and Methodology*,

Milton Keynes, Bloomington.

Hess, D. J. 1997, *Science Studies: An Advanced Introduction*, New York University Press, New York and London.

Hoby, K. 1999, 'Blood-Clot Victim Advocates Tests Before Pill Prescribed', *The Press*, 17 March, p.3.

Hooks, B. 1992, *Black Looks: Race and Representation*, South End Press, Boston.

Horrocks, R. 1983, 'The Invention of New Zealand', *And*, vol. 1, pp.9-30.

Huff, D. 1973, *How to Lie with Statistics*, Victor Gollancz Limited, London.

Irwin, A. 1995, *Citizen Science: A Study of People, Expertise and Sustainable Development*, Routledge, London and New York.

Irwin, A. & Wynne, B. (eds) 1996, *Misunderstanding Science? The Public Reconstruction of Science and Technology*, Cambridge University Press, Cambridge.

Jick, H., Jick, S., Gurewich, V., Myers, M. & Vasilakis, C. 1995, 'Risk of Idiopathic Cardiovascular Death and Non-Fatal Venous Thromboembolism in Women Using Oral Contraceptives with Differing Progestagen Contents, *Lancet*, vol. 346, pp. 1589-1593.

Johnson, S. 2000, *Health Care and the Law*, Brooker's, Wellington.

Jones, A. 1997, 'Teaching Post-structuralist Feminist Theory in Education: Student Resistances', *Gender and Education*, vol. 9, no. 3, pp.261-269.

Katovich, M. A. 1995, 'Couch the Bricoleur: Using Ethnographic and Laboratory Traditions to Establish Data Careers', *Symbolic Interaction*, vol. 18, no. 3, pp.283-301.

Kendall, C. 1995, 'The Construction of Risk in AIDS Control Programs', in *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World*, (eds) R. G. Parker & J. H. Gagnan, Routledge, London and New York.

Ketting, E. 1996, 'Third Generation Oral Contraceptives: CSM's Advice will Harm Women's Health Worldwide', *British Medical Journal*, no. 312.

Klein, R. D. 1983, 'How to do What we Want to do: Thoughts about Feminist Methodology', in *Theories of Women's Studies*, (eds) G. Bowles & R. D. Klein, Routledge & Keagan, London, Boston, Melbourne.

Klein, R. 1996, '(Dead) Bodies Floating in Cyberspace: Post-modernism and the Dismemberment of Women', in *Radically Speaking: Feminism Reclaimed*, D. Bell & R. Klein (eds), Spinifex Press, Melbourne.

Kondo, D. 1990, 'The Eye/I', in *Crafting Selves*, Chicago University Press, Chicago.

Latour, B. 1987, *Science in Action*, Harvard University press, Cambridge.

Latour, B. 1999, *Pandora's Hope: Essays on the Reality of Science Studies*, Harvard University Press, Cambridge and London.

Law, J. & Hassard, J. (eds), 1999, *Actor Network Theory and After*, Blackwell, Oxford.

Ledingham, JGC. & Weatherall, DJ. 1996, 'Pulmonary Embolism', in *Oxford Textbook of Medicine*, Oxford University Press, Oxford.

Lévi-Strauss, C. 1968, *The Savage Mind*, Weidenfeld & Nicolson, London.

Luhmann, N. 1993, *Risk: A Sociological Theory*, Aldine de Gruyter, New York.

Lupton, D. 1994, 'The Great Debate about Cholesterol: Medical Controversy and the News Media', *Australia and New Zealand Journal of Sociology*, vol. 30, no. 3, pp. 334-339.

Lupton, D. 1999a, *Risk*, Routledge, London and New York.

Lupton, D. (ed) 1999b, *Risk and Sociocultural Theory: New Directions and Perspectives*, Cambridge University Press, Cambridge.

Lynch, M. & Woolgar, S. 1988, 'Introduction: Sociological Orientations to Representational Practice in Science', *Human Studies*, vol. 11, nos. 2-3, pp. 99-116.

MacKinnon, C. A. 2000, 'Points Against Postmodernism', *Chicago-Kent Law Review*, vol. 75, pp.687-711.

Marks, L. 1999, "Not Just a Statistic: the History of USA and UK Policy over Thrombotic Disease and the Oral Contraceptive Pill, 1960s-1970s', *Social Science and Medicine*, vol. 49, pp. 1139-1155.

Marscia-Lees, F. Sharpe, P. & Cohen, C. B. 1989, 'The Postmodern Turn in Anthropology: Cautions from a Feminist Perspective', *Signs*, vol.15, no.1, pp.7-33.

Medsafe (New Zealand Medicines and Medical Devices Safety Authority, A Business Unit of MOH), February 1999, *Oral contraceptives and Blood Clots*, Medsafe, Wellington.

Medsafe (New Zealand Medicines and Medical Devices Safety Authority, A Business Unit of the MOH), June 2000, *An Update on Oral Contraceptives and Blood Clots*, Medsafe, Wellington.

Middleton, S. 1993, *Educating Feminists: Life Histories and Pedagogy*, Teacher's College Press, New York and London.

Mies, M. 1983, 'Towards a Methodology for Feminist Research', in *Theories of Women's Studies*, (eds) G. Bowles & R. D. Klein, Routledge and Keagan, London, Boston, Melbourne.

Ministry of Health (MOH), January 1999, *Advice for Women about Oral Contraceptives: Consumer Information*, MOH, Wellington.

Miriyana, A. 1999, 'Pill Victims' Risk Factors Were Missed', *Sunday Star Times*, 30 May, p.A8.

Myers, G. F. 1979, *The Art of Software Testing*, Wiley, New York.

Naffine, N. 1990, *Law and the Sexes*, Unwin Hyman, London.

Oaks, L. 1994, 'Fetal Spirithood and Fetal Personhood: the Cultural Construction of Abortion in Japan', *Women's Studies Int. Forum*, vol. 17, no. 5, pp. 511-523.

Oudshoorn, N. 1994, *Beyond the Natural Body: An Archeology of Sex Hormones*, Routledge, London and New York.

Parker, R. G. & Gagnan, J. H. 1995, *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World*, Routledge, London and New York.

Parsons, E. & Atkinson, P. 1992, 'Lay Constructions of Genetic Risk', *Sociology of Health and Illness*, vol. 14, no. 4, pp. 437-455.

Pegasus Medical Group, 2000, *What you should Know about the Risks of Taking Oral Contraceptives*, Pegasus Medical Group, Christchurch.

Peterson, A. 1997, 'Risk, Governance and the New Public Health', in *Foucault, Health and Medicine*, (eds) A. Peterson & R. Bunton, Routledge, London and New York.

Pharmac, 1996, 'Return to Monthly Dispensing', *Pharmac*, Wellington.

Pharmac, 1998, 'New Zealand Pharmaceutical Schedule', *Pharmac*, Wellington.

Pharmac [online] http://www.pharmac.govt.nz [2001, November 5].

Phillimore, P. & Moffatt, S. 1994, 'Discounted Knowledge: Local Experience, Environmental Pollution and Health', in *Researching the People's Health*, (eds) J. Popay & G. Williams, Routledge, London and New York.

Pihama, L. 1988, 'No, I will not be a Post...', *Te Pua 2*, Te Puawaitangi, Whare Wananga o Tamaki Makaurau, pp. 35-37.

Pool, I. 1999, *New Zealand's Contraceptive Revolutions*, University of Waikato, Hamilton.

Powers, A. 1999, 'Newspaper Coverage of the Breast Implant Controversy', *Women and Health*, vol. 30, no. 2, pp. 83-98.

Preston, L. 1996, 'Women and Alcohol: Defining the Problem and Seeking Help', *International Journal of Sociology and Social Policy*, vol. 16, no. 5, pp.52-72.

Price, F. 1996, 'Now You See it, Now You Don't: Mediating Science and Managing Uncertainty in Reproductive Medicine', in *Misunderstanding Science? The Public Reconstruction of Science and Technology*, (eds) A. Irwin & B. Wynne, Cambridge University Press, Cambridge.

Ribbens, J. 1989, 'Interviewing – An Unnatural Situation?', *Women's Studies Int. Forum*, vol. 12, no. 6, pp.579-592.

Rohrmann, B. 1996, *Perception and Evaluation of Risks: Findings for New Zealand and Cross-Cultural Camparisons*, Lincoln University, Lincoln.

Rorty, A. O. 1995, 'The Science of the Humane and the Humanism of Science', *Culture, Medicine and Psychiatry*, vol. 19, no. 2, pp. 217-223.

Safer, D. Krager, J. 1992, 'Effect of a Media Blitz and a Threatened Lawsuit on Stimulant Treatment', *Journal of American Medical Association*, vol. 268, no. 8, p. 1004.

Sartwell, P. & Stolley, P. 1982, 'Oral Contraceptives and Vascular Disease', *Epidemiological Reviews*, vol.4, pp.95-109.

Saussure, F. *Course in General Linguistics*, McGraw Hill, New York.

Scott, J. W. 1992, 'Experience', in *Feminists Theorize the Political*, (eds) J. Butler & J. W. Scott, Routledge, London and New York.

Seaman, B. 1969, *The Doctor's Case Against the Pill*, Hunter House, Alameda, CA.

Sheldon, S. & Thomson, M. 1998, *Feminist Perspectives on Health Care Law*, Cavendish, London, Sydney.

Shildrick, M. & Price, J. 1996, 'Breaking the Boundaries of the Broken Body', *Body and Society*, vol.2, no.4, pp.93-113.

Shildrick, M. 1997, *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio)Ethics*, Routledge, London and New York.

Shilling, C. 1992, *The Body and Social Theory*, Sage, London.

Singer, L. 1992, 'Feminism and Postmodernism', in *Feminists Theorize the Political*, (eds) J. Butler & J. W. Scott, Routledge, London and New York.

Singleton, V. & Michael, M. 1993, 'Actor-Networks and Ambivalence: General Practitioners in the UK Cervical Screening Programme', *Social Studies of Science*, vol. 23, pp.227-64.

Smail, S., Muir Gray, J. & Tilden, E. 1984, *Every Woman's Medical Guide: To Help You Understand and Care for your Body*, Octopus Books, London.

Smyth, H. 2000, *Rocking the Cradle: Contraception, Sex and Politics in New Zealand*, Steele Roberts Ltd, Wellington.

Somers, M. 1994, 'The Narrative Constitution of Identity: A Relational and Network Analysis', *Theory and Society*, vol.23, no.5, pp.605-649.

Spirer, H. F. 1987, *Misused Statistics: Straight Talk for Twisted Numbers*, Marcel Dekker Inc, New York.

Spitzer, W. O., Lewis, M. A., Heinemann, L., Thorogood, M. & MacRae, K. 1996, 'Third Generation Oral Contraceptives and Risk of Venous Thromboembolic Disorders: An International Case Control Study', *British Medical Journal*, vol. 312, pp. 83-88.

Spitzer, W. O. 1997, 'The 1995 Pill Scare Revisited: Anatomy of a Non-Epidemic', *Human Reproduction*, vol. 12, pp. 2347-57.

Spivak, G. C. 1993, *Outside in the Teaching Machine*, Routledge, New York.

Spivak, G. C. 1999, *A Critique of Postcolonial Reason: Towards a History of the Vanishing Present*, Harvard University Press, Cambridge.

Spretnak, C. 1996, 'The Disembodied Worldview of Deconstructive Post-Modernism', in *Radically Speaking: Feminism Reclaimed*, D. Bell & R. Klein (eds), Spinifex, Melbourne.

Stacey, M. 1994, 'The Power of Lay Knowledge', in *Researching the People's Health*, (eds) J. Popay & G. Williams, Routledge, London and New York.

Stadel, B. 1981, 'Oral Contraceptives and Cardiovascular Disease', *England Journal of Medicine*, vol.305, pp.612-617.

Stanley, L. & Wise, S. 1983, 'Back into the Personal or: Our Attempt to Construct Feminist Research', in *Theories of Women's Studies*, (eds) G. Bowles & R. D. Klein, Routledge, London and New York.

Star, S. L. & Griesemer, J. R. 1989, 'Institutional Ecology, Translations and Boundary Objects: Amateurs and Professionals in Berkley's Museum of Vertebrate Zoology', *Social Studies of Science*, vol. 19, pp. 387-420.

Suleri, S. 1989, *Meatless Days*, Chicago University Press, Chicago.

The Dominion, 1995, 'Ministry Says Pills Safe to Keep Taking', 27 October, p.3.

The Jerusalem Bible, 1992, Koren Publishers Ltd, Jerusalem.

Thompson, D. 1996, 'The Self-Contradiction of "Post-modernist" Feminism', in *Radically Speaking: Feminism Reclaimed*, D. Bell & R. Klein, Spinifex, Melbourne.

Tolich, M. & Davidson, C. 1999, *Starting Fieldwork: An Introduction to Qualitative Research in New Zealand*, Oxford University Press, Auckland, Oxford, New York, Melbourne.

Townshend, P., Sellman, D. & Haines, R. 1998, 'The Cartwright Report Ten Years on: The Obligations and Rights of Health Consumers and Providers', *New Zealand Medical Journal*, 9 October, pp. 390-392.

Treichler, P. A., Cartwright, L. & Penley, C. (eds) 1998, *The Visible Woman: Imaging Technologies, Gender and Science*, New York University Press, New York and London.

Tuckett, D., Boulton, M., Olson, C. & Williams, A. (eds) 1985, *Meetings Between Experts: An Approach to Sharing Ideas in Medical Consultations*, Tavistock, London and New York.

Turkle, S. & Papert, S. 1990, 'Epistemological Pluralism: Styles and Voices within the Computer Culture', *Signs*, vol. 16, no. 1, pp.128-157.

Tuhiwhai Smith, L. 1999, *Decolonizing Methodologies: Research and Indigenous Peoples*, Zed Books, University of Otago, London, Dunedin.

Turner, B. S. 1995, 'Risk Society and the New Regime of Disease', in *Medical Power and Social Knowledge*, Sage, New Delhi and London.

Usher, J. M. (ed) 1997, *Body Talk: the Material and Discursive Regulation of Sexuality, Madness and Reproduction*, Routledge, London and New York.

Vessey, M. P. & Inman, W. H. W. 1973, 'Speculations about Mortality Trends from Venous Thromboembolic Disease in England and Wales and their Relation to the Pattern of Oral Contraceptive Usage', *The Journal of Obstetrics and Gynaecology of the British Commonwealth*, vol. 80, pp. 562-566.

Wallace, D. R. 1986, *An Overview of Computer Software Acceptance Testing*, US Department of Commerce, Gaithersburg, MD.

Waters, K. 1996, '(Re)Turning to the Modern: Radical Feminism and the Postmodern Turn', in *Radically Speaking: Feminism Reclaimed*, D. Bell & R. Klein (eds), Spinifex, Melbourne.

Wedde, I. 1995, 'The Tyranny of the Collection', in *How to be Nowhere*, Victoria University Press, Wellington.

Weedon, C. 1987, *Feminist Practice and Poststructuralist Theory*, Basil Blackwell, Oxford.

Weinstein, D. 1991, *Heavy Metal: A Cultural Sociology*, Lexington, New York, Oxford.

Weinstein, D. & Weinstein, M. A. 1991, 'Georg Simmel: Sociological Flaneur Bricoleur', *Theory, Culture & Society*, vol. 8, pp.151-168.

Weinstein, D. & Weinstein, M. A. 1993, 'Postmodernizing (Macro)Sociology', *Sociological Inquiry*, vol. 63, no. 2, pp.224-238.

Whiteman, M., Cui, Y., Flaws, J., Langenberg, P. & Bush, T. 2000, 'Media Coverage of Hormone Replacement Therapy (HRT) and Breast Cancer: Stop the Presses', *American Journal of Epidemiology*, vol. 151, no. i11, p. 592.

Williams, G. & Popay, J. 1994, 'Lay Knowledge and the Privilege of Experience', in *Challenging Medicine*, (eds) J. Gabe & D. Kelleher, Routledge, London and New York.

Williams, S. J. & Bendelow, G. (eds), 1998, *The Lived Body: Sociological Themes, Embodied Issues*, Routledge, London, New York.

Winner, L. 1986, 'Do Artifacts have Politics?' in *The Whale and the Reactor: A Search for Limits in an Age of High Technology*, University of Chicago Press, Chicago.

World Health Organisation Collaborative Study of Cardiovascular Disease and Steriod Hormone Contraception. 1995a, 'VTE Disease and Combined Oral Contraceptives: Results of an International Multi-Centre Case-Control Study', *Lancet*, vol. 346, pp. 1575-1581.

World Health Organisation Collaborative Study of Cardiovascular Disease and Steriod Hormone Contraception. 1995b, 'Effect of Different Progestagens in Low Oestrogen Oral contraceptives on Venous Thromboembolic Disease: Results of an International Multi-Centre Case-Control Study', *Lancet*, vol. 346, pp. 1582-1588.

Worpole, K. 1990, 'Total Culture', in *Marxism Today*, Communist Party of Great Britain, London.

Yeats, W. B. 1928, *The Death of Synge and other Passages from an Old Diary*, Macmillan, London.

Yokohama, M. 1993, 'Emergence of Anti-Prostitution Law in Japan – Analysis from Sociology of Criminal Law', *International Journal of Comparative and Applied Criminal Justice*, vol. 17, no. 2, pp. 212-218.

Yokohama, M. 1995, 'Analysis of Prostitution in Japan', *International Journal of Comparative and Applied Criminal Justice*, vol. 19, no. 1, pp. 48-60.

CASE LAW

Canterbury v Spence 464 F2d 772 DC [1972]

Hall v Brooklands Auto Racing Club 1 KB 205 CA [1933]

Rogers v Whittaker 175 479 CLR [1992]

Salgo v Leland Stanford Uni Board of Trustees 317 P2d (Cal Dis App) [1957]

Smith v Auckland Hospital Board 191 NZLR (CA) [1965]

APPENDIX 1

RESEARCH ON THE CONTRACEPTIVE PILL

Shalom! I am researching the use of oral contraceptives for my MA degree in sociology at the University of Canterbury. My research explores the ongoing controversy in the mass media about the third generation oral contraceptive pill in Aotearoa/New Zealand. It looks at different responses to this controversy. I am interested in talking to women who were/are using the third generation oral contraceptive pill. Please contact me if you are prepared to talk about your use of oral contraceptives and your responses to media debate about this contraceptive.

Confidentiality is assured. This project has ethical approval from both the University of Canterbury and the Canterbury Ethics Committee. An information sheet is attached which provides further detail about my study.

Thank you for taking the time to read this notice.

I would be most grateful if any interested women could contact me:

Jennifer McDonald

Email: jlm66@student.canterbury.ac.nz

Phone: 389 9231 (hm)

APPENDIX 2

INFORMATION SHEET

1. Who is the Researcher?

I am conducting this research as part of my MA thesis in sociology at the University of Canterbury. I would like to invite you to participate in my study.

2. Research Title: The 1999/2000 Aotearoa/New Zealand Oral Contraceptive Pill Controversy: Alternative Stories

3. What is the study about?

The goal of this study is to explore the ongoing third generation oral contraceptive pill controversy that is occurring in this country. Several women have died from blood clots allegedly caused by the pill and others are experiencing health difficulties. Many different people are involved in this controversy: medical professionals, consumers, the media, the government, drug companies etc. I would like to hear what people in these different positions have to say about the pill controversy. I will also be analysing media representations of this controversy.

I am particularly interested in the stories of women who were on this type of oral contraceptive when they heard about the health risks associated with it. Specifically, I am interested in talking to women who are aware of this contraceptive controversy. I am interested in speaking to women who consulted health providers about the pill during this controversy. However, I would also like to talk to women who have not consulted health providers about this pill controversy.

These are some of the questions I would like to ask:
How did you become aware of this contraceptive controversy? What were your responses to it? If you consulted a health provider, what were your experiences during your consultation(s) about the pill? Did you continue taking the third generation pill or not? Did anything influence your decision? What did you think of the way that the media portrayed this pill controversy?

4. What is a Third Generation Oral Contraceptive?

The formulation of oral contraceptives has changed since they were introduced in the early 1960s. The hormonal content, particularly of oestrogen, has been reduced. Third generation pills contain the progestogens desogestrel, gestodene and norgestimate, in combination with oestrogen. Consequently, they are often called combined oral contraceptives.

There are currently four main brands of combined oral contraceptives containing either the progestogen desogestrel or gestodene available in New Zealand. These products have the following brand names: Femodene, Marvelon, Mercilon and Minulet. These contraceptive pills were introduced into New Zealand during the 1980s.

5. What will you have to do?

If you agree to participate in this study, you will be asked to meet with Jenny McDonald for one interview which will be about one hour to one hour and thirty minutes in duration. This interview will take place at a time that is convenient to you. It will normally be conducted in private. The interview will be audio tape recorded. The interview will ask you about the length of time you have been on various types of oral contraception, but especially third generation pills. I will also ask you questions about your responses to this contraceptive controversy. Finally, I will talk to you about your responses to the media's treatment of this ongoing contraceptive pill controversy.

6. Ethical Approval

This study has been given ethical approval from both the University of Canterbury Human Ethics Committee and the Canterbury Ethics Committee.

7. What are the participant's rights?

Participation in this study is voluntary. If you decide not to participate, this will not affect your ongoing health care.

If you agree to take part in this study, you have the right to:

(a) decline to participate at any time without having to give a reason. If you decide to withdraw none of the information you have provided will be used in the study.
Your withdrawal will also have no effect on your ongoing health care

(b) refuse to answer any particular question.

(c) ask any further questions about the study that occur to you.

(d) ask for the audio tape to be turned off at any time during participation.

(e) discuss your participation in this study with the researcher, the researcher's supervisors, or anyone else you choose.

(f) ask to review your interview transcript.

(g) be given a summary of the study's findings when it is concluded.

(h) provide information on the understanding that it is completely confidential to the researcher and that you will not be able to be identified from the reports, publications and seminars that are prepared from the study.

(i) determine the disposal of interview tapes, transcripts of interviews and any other personal documents made available to the researcher.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Services Consumer Advocate, telephone (03) 377 7501 or 0800 377 766 outside Christchurch.

You are also welcome to contact any of the following people for further information, clarification or questions about this study:

Jenny McDonald (postgraduate researcher) 389 9231 (hm) or jlm66@student.canterbury.ac.nz
Rosemary Du Plessis (primary supervisor) 364 2878 (wk) or r.duplessis@soci.canterbury.ac.nz
Keiko Tanaka (associate supervisor) 364 2978 (wk) or k.tanaka@soci.canterbury.ac.nz

APPENDIX 3

CONSENT FORM

The 1999/2000 Aotearoa/New Zealand Oral Contraceptive Pill Controversy: Alternative Stories

I have read and understood the description of the above-named project which is provided on the Information Sheet. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.

I agree to provide information to the researcher on the understanding that confidentiality will be preserved and that the information will only be used for this research, seminars, conferences and publications arising from this research project.

I also understand that I may withdraw from the project, including withdrawal of any information that I have provided, at any time.

I agree to the researcher audio taping the interview with me. I understand that direct quotations from the interview may be used in reports about the study but that I will not be identified. The audio tape and transcripts will be destroyed when the study is concluded. I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

If you would like to receive a summary of the results of the study please indicate and fill out your postal address below.

"I would like to receive a copy of the study's findings"
Delete one: YES/NO
If yes, please fill in your postal address: _____

_____

_____

_____

Based on the above conditions, I agree to participate in this project.

Signed: _____

Name: _____

Date: _____

Researcher's Name: _____

Researcher's Signature: _____

Date: _____

APPENDIX 4

INTERVIEW SCHEDULE FOR HEALTH PROVIDERS

* QUESTIONS FOR ALL HEALTH PROVIDERS

1. Questions for the Researcher

Is there anything that you would like to ask me about this study?

2. Current Third Generation Oral Contraceptive Debate

How did you first become aware of the debate surrounding third generation oral contraceptives?

What was your initial reaction(s) and response(s) to this contraceptive debate?

Has your position on this contraceptive controversy changed?

3. The Media

Are you aware of the media coverage of the third generation 'pill scare' over the last five years?

If so, what is your response(s) to the media's representation of this debate?

4. Professional Opinion on Contraception

What is your professional opinion about the third generation oral contraceptives?

What side effects or risks do you associate with oral contraceptives?

What side effects or risks do you associate with third generation oral contraceptives?

What benefits do you associate with oral contraceptives?

What benefits do you associate with third generation oral contraceptives?

Are third generation oral contraceptives safer/the same/more dangerous than older products?

According to your knowledge, have third generation pills ever been promoted as being safer than older formulations?

How important is the safety of contraceptive methods?

How important is the effectiveness of contraceptive methods?

How do you assess the risk for patients associated with different contraceptive methods?

5. Doctor-Patient Relationships

Have any of your patients spoken to you about the debate surrounding the third generation pills?

Approximately how many patients have contacted you about issues relating to the current third generation oral contraceptive debate?

What was discussed?
Do your patients speak to you about their contraceptive options?

What advice or information do you give to patients about contraception?

What is your understanding of 'informed consent/choice'?

How can this be achieved in relationships with consumers of health care?

Do you find it easy/difficult to convey medical information, such as contraceptive details, to patients?

What sort of information is available to women who are making decisions about contraceptive options?

How do women get access to this information?

Of your patients who use contraception, approximately what percentage are Maori, Pacific Island, Pakeha, Asian, Jewish, or other ethnic identities?

6. Impact of Controversy

Have you seen an increased/decreased/static number of patients about contraception in the last five years since this controversy began?

Did any of your patients stop using third generation oral contraceptives as a result of this debate?

Approximately what percentage of your patients stopped using third generation oral contraceptives as a response to the debate about theses pills?

Do you have any opinion about why patients would continue or stop usage of the third generation pill?

Are there any differences/similarities reflected in this contraceptive controversy as opposed to earlier 'pill scares'?

7. Other

Are there any other relevant issues/concerns that you would like to raise?

* QUESTIONS FOR THE HEALTH ALTERNATIVES FOR WOMEN (THAW)

How did you become involved with THAW?

How long have you been with THAW?

Can you tell me about THAW's approach to health care in general?

What is THAW's position on contraceptive choices?

How do you advertise the services provided by THAW?
Do you need to?

*QUESTIONS FOR NATURAL FAMILY PLANNING (NFP)

Can you please explain to me what NFP is?

How did you become interested in NFP?

How long have you been involved with NFP?

What are the advantages and disadvantages of this contraceptive method?

Are there any side effects or risks associated with NFP?

How do you define the 'natural' in Natural Family Planning?

What is the difference between natural and synthetic hormones?

How do you 'recruit' prospective patients?
Do you need to?

I have noticed some of your advertisements in *The Observer*.
Why do you choose to advertise in this publication?

Do you advertise in any other publications?

What is different about your approach to contraceptive issues?

What is different about your approach to health care in general?

* QUESTIONS FOR CANTERBURY COLLEGE OF NATURAL MEDICINE (CCNM)

Can you please explain to me what natural medicine is?

How did you become interested in natural medicine?

How long have you been practising as a naturopath?

Do you prescribe oral contraceptives?

If not, who would you refer patients to?
Why?

How would you define natural as opposed to synthetic hormones?
Are these appropriate labels?

What constitutes a natural contraceptive method?
Why?

What is different about your approach to contraception?

What is different about your approach to health care in general?

How do you 'recruit' prospective patients?
Do you need to?

APPENDIX 4

INTERVIEW SCHEDULE FOR ORAL CONTRACEPTIVE USERS

1. Questions for the Researcher

Is there anything else that you would like to ask me about this research or interview?

2. Contraceptive History

How long have you used a third generation oral contraceptive?

What brand (e.g. Mercilon, Marvelon, Femodene, Minulet) were/are you using?

Have you been on any other type of oral contraceptive?

Was a third generation pill the first type of oral contraceptive that you were prescribed?

Why were/are you taking oral contraceptives?
(For example, was it to prevent conception, regulate menstruation, regulate hormonal imbalance, reduce headaches or acne, or for any other reason.)

Have you used any other contraceptive method, such as Natural Family Planning, IUD, condoms etc?

If you changed contraceptive methods, why did you make this shift?

What benefits/risks do you associate with different contraceptive methods?

3. Prescription of Oral Contraceptives

Was there any particular reason why you were prescribed a third generation oral contraceptive?

Were any other contraceptive methods discussed with you?

How did you decide what sort of contraception to use?

Does anything influence your choice of contraception?

Who did you seek advice from?
Why?

Are there any cultural and/or religious issues, that you are comfortable discussing, that are relevant to contraceptive choices that you make?

Are these concerns respected and understood by members of the medical profession, family, friends etc?

In your experience, is it easy or difficult to talk about oral contraception (or contraception in general) with:
a) your health provider?
b) your family?

c) your friends?
d) your partner?

4. Ongoing Debate Surrounding Third Generation Oral Contraceptives

Are you aware of the current debate surrounding the safety of third generation oral contraceptives?

If yes to the question above, how did you become aware of the controversy?
(e.g. through family, friends, media?)

Have you spoken to other people about the contraceptive pill during/since this controversy was debated in the media?

If so, what did you talk about?

What action, if any, did you take after you read or heard about the side effects of using this contraceptive?

Why did you choose to take this action?

Why did you choose not to take any action?

Has your response to this controversy changed over time?

5. Experiences with Health Providers

Did you consult a health provider after reading or hearing about the side effects of third generation oral contraceptives?

What sort of health provider did you consult?
(For example, a naturopath, family GP, specialist, Student Health etc?)

Why did you decide to consult this health provider?

Why did you decide not to consult a health provider?

Did you talk to anyone else about the contraceptive pill at this time?

If you consulted a health provider, what were your experiences during this consultation?

Were you satisfied/dissatisfied with the information about oral contraceptives and other contraceptive choices that was presented to you?

Do you feel that you have enough information about the pill?

How much do you think that users/consumers of the pill should know about their contraception?

Did your health provider give you this document about third generation pills?
(RESEARCHER SHOW DOCUMENT TO PARTICIPANT)

Did you read it?
Why/Why not?

Did your response to the controversy change after your consultation with this health provider about third generation contraceptive pills?

6. Media's Representation of Controversy

Do you think that the media provided useful information about the third generation pill?

Some media reports suggest that abortion rates rise after 'pill scares'. What do you think about this?

7. Side Effects and/or Benefits of Oral Contraceptives?

Have you had any side effects, either "minor" or "major", from using the pill?
(Minor side effects include headaches and dizzy feelings; whereas major side effects include blood clots.)
If so, how do you feel about this?

Did you consider third generation oral contraceptives to be safer/the same/or more dangerous than older types of oral contraceptives?

Is the safety (e.g. minimal side effects) or effectiveness (e.g. how well it prevents conception) of a contraceptive method more important to you?

In your experience, what are the benefits of using oral contraceptives?

Do you think that you are a "responsible" user of contraception?

Has your health provider helped you to choose among different forms of contraception?

Has being on the pill made any significant changes to your life?

8. Extras?

Do you have any other thoughts/concerns/issues that you would like to raise?

Is there anything that you would like to ask me about my experiences on the pill?

Is there anything that you would like to comment on about the interview?

THANK YOU VERY MUCH!!

APPENDIX 4

INTERVIEW QUESTIONS FOR MEDICAL LAW SPECIALIST

1. Questions for the Researcher

Is there anything that you would like to ask me about my study?

2. Background

Why did you become interested in medical law issues?

Do you mainly represent health consumers or health professionals?
How would you explain this?

In your experience, what are health consumers' expectations about and understandings of their rights?

In your experience, have health consumers been proactive about medico legal issues or not?

Are medical legal issues in New Zealand different from other countries?

If so, why do you think this is?

3. Current Third Generation Oral Contraceptive Debate

Are you aware of the ongoing debate surrounding the safety of third generation oral contraceptives?

How did you become aware of this debate?

In your opinion, what are the key medical legal issues highlighted by this contraceptive controversy?

4. Legislative Codes

What are the principal legislative codes (i.e. Acts, regulations, ethical standards etc) that pertain to medico legal issues?

What are the principal legislative codes that pertain to reproductive rights?

Have there been any reported cases in this area in New Zealand?

How authoritative is the Cartwright Inquiry decision?

Are any of the Cartwright Inquiry findings relevant to the current oral contraceptive debate?

5. Rights

How do you define a "right"?

What constitutes reproductive rights?

What are patients' rights during consultations with health providers?

What are the legal rights of patients with respect to the health risks associated with the prescription of contraceptives?

What are health providers' rights during consultations with patients?

What are health providers' responsibilities during consultations with patients?

Do patients have any right to claim damages from pharmaceutical companies?

Is it possible for the courts to reconcile universal human rights with some religious laws which regulate women's contraceptive choices?

6. Informed Consent and Informed Choice

What is your understanding of the concept 'informed consent'?

Do you think that this concept is realistic and/or attainable?

How much information are health professionals required to disclose to patients?

In what ways are health providers required to disclose such information?
(For example, is a pamphlet satisfactory?)

To what extent are health professionals required to canvass the side effects and risks of products such as third generation oral contraceptives?

To what extent is it possible for the consumer, rather than the health provider, to make contraceptive choices?

What is your understanding of the doctor-patient relationship?

Is there are legal concept called 'informed choice'?

If so, how would you define this concept?

What does informed choice involve?

How is it different from and/or similar to informed consent?

How can informed choice be achieved in health care relationships?

7. The 'Legal Body'

Legal theorists have considered how the law defines the female reproductive body and also the question of ownership of the body.

How are these issues addressed in New Zealand law?

What is your response to the adequacy of this law?

Is the law in New Zealand explicit about rights pertaining to bodies?

What law is relevant?

How is it relevant?

8. Contraception Advertisements

Are there any regulations which pharmaceutical companies must follow when they advertise oral contraceptives in medical journals?

Other

Is there anything else which you would like to raise?

THANK YOU VERY MUCH!!

APPENDIX 5

INTERVIEW PARTICIPANT DETAILS

- **Contraceptive Consumers**

Pseudonym	*Age Bracket*	*Contraceptive status*	*Access*
1. Emily	20-30	Former OC user. Currently uses condoms. Plans to learn NFP.	Responded to notice placed at THAW.
2. Anne-Maree	20-30	Used OCs prior to and during 3GOC controversy. Currently an OC user.	Contacted through 'snowballing'.
3. Zena	20-30	Former OC user. Currently uses NFP.	Contacted through a representative associated with a NFP organisation.
4. Marion	20-30	Used OCs prior to and during 3GOC controversy. Currently an OC user.	Contacted through 'snowballing'.
5. Phillipa	20-30	Used condoms for 5/6 years. Used OCs prior to and during 3GOC controversy. Currently an OC user.	Contacted through a representative associated with Canterbury College of Natural Medicine.
6. Sarah	30-40	Previous, long-term OC user. Currently uses NFP.	Responded to newspaper notice.
7. Jacqueline	40-50	Previous OC user. Currently uses NFP.	Contacted through a representative of a health organisation.
8. Ginny	20-30	Previous OC user. Currently uses NFP.	Responded to notice at Christchurch tertiary student health centre.
9. Janet	30-40	OC user prior to and during 3GOC controversy. Currently OC user.	Responded to notice placed at Christchurch School of Medicine.
10. Heidi	20-30	OC user prior to and during OC controversy. Currently OC user.	Contacted through 'snowballing'.
11. Ellen	20-30	Previous OC user. Currently diaphragm user.	Contacted through 'snowballing'.

- **Health Providers**

Name or Pseudonym	*Age Bracket*	*Health Care Position*	*Access*
1. Margaret Kyle	20-30	Midwife	Contacted through 'snowballing'.
2. Cindy Carmichael	30-40	THAW employee. Registered nurse.	Letter to THAW.
3. Peter Kearns	50 and above	Co-Director of Canterbury College of Natural Medicine and naturopath.	Letter to Canterbury College of Natural Medicine.
4. Judith Sim	40-50	NFP practitioner and teacher.	Letter and phone call to her NFP practice.
5. Rosemary Reid	40-50	Doctor at a Christchurch Hospital.	Responded to a notice placed at a Christchurch hospital.
6. Luxi (pseudonym)	30-40	Doctor at Christchurch Family Planning Association Clinic.	Letter to FPA.
7. Doctor X (pseudonym)	50 and above	Doctor at a Christchurch Hospital.	Responded to notice placed at a Christchurch hospital.

- **Medical Law Specialist**

Name (no pseudonym required)	*Age Bracket*	*Access*
1. Antonia Fisher	30-40	Email and letter to law firm.

APPENDIX 6

PARTICIPANTS' DEMOGRAPHIC FORM

1. Please indicate your age bracket by circling a category below:

   Under 20 years

   20 – 30

   30 – 40

   40 – 50

   50 and above

2. How would you describe your ethnicity?

3. Do you identify with a particular religious group?
   If yes, how would you describe your religion?

4. What is your principal occupation?

5. What is your highest educational qualification?

6. Do you have any other training or expertise?

7. Would you like to tell me anything else about yourself that you think is relevant for this study?

*** Thank you very much for participating in this study!

APPENDIX 7

An Update on Oral Contraceptives and Blood Clots

MEDSAFE
NEW ZEALAND MEDICINES AND MEDICAL DEVICES SAFETY AUTHORITY
A BUSINESS UNIT OF THE MINISTRY OF HEALTH

Before prescribing a contraceptive, your doctor is required to discuss the options with you and to explain the risks and benefits. Your doctor will also need to check whether you have any risk factors that would prevent you from using an oral contraceptive ('the Pill') or increase your risk of having a blood clot or other side effect. All benefits and risks need to be considered when deciding which contraceptive is best for the individual woman.

This information is about blood clots that may, although very rarely, occur with some combined oral contraceptives.

What is a blood clot?

The blood clots associated with oral contraceptives occur in the veins of the legs and cause a blockage. They may cause death when pieces of the clot dislodge and travel to the lungs, but this happens rarely. (These blood clots are not those that may occur with your period.)

How often do blood clots occur with oral contraceptives?

Blood clots occur rarely with oral contraceptives, and deaths from blood clots are even more rare.

The risk of having a blood clot depends on a number of factors. It increases with age and is also affected by which pill is taken. For every 100,000 women taking the pill for a year, approximately 35 will develop a blood clot. One woman will die as a result of the blood clot. Compared to women not taking the pill, the odds of having a blood clot increase by 3-4 times for those on second generation pills and 6-8 times for those on third generation pills. Women using progestogen-only pills are thought to be at little or no increased risk of blood clots.

The following table lists the types of oral contraceptives available in New Zealand.

Type of oral contraceptive	Brands
Progestogen-only pill	Femulen, Microlut, Microval, Noriday
Combined oral contraceptives with low-dose oestrogen and progestogen or anti-androgen	
Second generation Pills containing the progestogens levonorgestrel or norethisterone	Brevinor, Brevinor-1, Levlen, Loette, Microgynon 20ED/30/30ED, Monofeme, Nordette, Norimin, Synphasic, Trifeme, Triphasil, Triquilar
Other Pills containing the anti-androgen cyproterone	Diane-35
Third generation Pills containing the progestogens desogestrel or gestodene	Femodene, Marvelon, Melodene, Mercilon, Minulet
Combined oral contraceptives containing high-dose oestrogen and progestogen	
Pills containing 50mcg oestrogen	Biphasil, Microgynon 50ED, Nordiol, Norinyl-1, Ovral

How often are blood clots fatal?

Of those who get a blood clot, about 3% will die. Given the wide use of oral contraceptives, two deaths a year from blood clots would be expected in New Zealand.

From 1990 -1999, 20 women using oral contraceptives died in New Zealand of a blood clot on the lungs. Of those who died 15 were using third generation pills. The risk of death with second generation pills is lower but still present.

What increases the risk of blood clots?

Some of the risk factors for blood clots are a previous blood clot, a close family member who has had a blood clot, being overweight, cancer, recent surgery, being immobilised and bad varicose veins Women who have had a previous blood clot should not take a contraceptive pill containing oestrogen. You should tell your doctor if any of these risk factors apply to you.

Your risk of having a blood clot can be increased temporarily, for example by a long flight, being immobilised by injury or illness, or by having surgery.

What are the symptoms and what should I do about them?

The symptoms of a blood clot in the leg are swelling, tenderness and pain, but a blood clot may occur without symptoms. Breathlessness and sharp chest pain can occur with a blood clot on the lungs. These symptoms can also occur for other reasons.

If you are taking an oral contraceptive pill and you develop any of these symptoms you should see a doctor immediately. You should be particularly alert to these symptoms if you have a risk factor for blood clots.

Your doctor may refer you to hospital for tests and treatment with blood-thinning medication. Treatment may last for several months and some women may have ongoing problems such as pain or swelling.

Who should I discuss this information with?

You should discuss your risk of blood clots with your doctor. There are a number of different types of contraceptives available, including non-hormonal barrier methods e.g. condoms. You should discuss with your doctor which type is likely to suit you best. You have a right to expect your doctor to explain this information in a way that you can understand.

Remember that blood clots are rare events in healthy women taking the contraceptive pill. Serious consequences are even more unlikely to occur. Your risk will be reduced even further if you see a doctor immediately if you get any symptom of a possible blood clot.

HP 3379

Published in June 2000 by Medsafe, PO Box 5013, Wellington, New Zealand.
This information is also available on Medsafe's web site:
http://www.medsafe.govt.nz/consumers/medicine/oralcontraceptives.htm

MINISTRY OF HEALTH
MANATŪ HAUORA

February 1999

169

APPENDIX 7

Oral Contraceptives and Blood Clots

MEDSAFE
NEW ZEALAND MEDICINES AND MEDICAL DEVICES SAFETY AUTHORITY
A BUSINESS UNIT OF THE MINISTRY OF HEALTH

Before prescribing a contraceptive, your doctor is required to discuss the options with you and to explain the risks and benefits. Your doctor will also need to check whether you have any risk factors that would prevent you from using an oral contraceptive ('the Pill') or increase your risk of having blood clot or other side effect. All benefits and risks need to be considered when deciding which contraceptive is best for the individual woman.

This leaflet is designed to give you information about blood clots that may occur with some oral contraceptives.

What is a blood clot?

The blood clots associated with oral contraceptives occur in the veins of the legs and cause a blockage. They may cause death when pieces of the clot dislodge and travel to the lungs, but this happens rarely. (These blood clots are not those that may occur with your period.)

How often do blood clots occur with oral contraceptives?

Blood clots occur rarely with oral contraceptives, and deaths from blood clots are even more rare.

The risk of a normal healthy woman developing a blood clot in one year is 1 in 30,000. The risk of blood clots is increased by pregnancy. Taking oral contraceptives containing oestrogens also increases the risk of blood clots, but not as much as being pregnant. The risk depends on the type of oral contraceptive (see table).

Type of oral contraceptive	Brands	Risk of blood clots per year
Progestogen-only pill	Femulen, Microlut, Microval, Noriday	1 in 30,000 women (No increase in risk)
Combined oral contraceptives with low-dose oestrogen and progestogen or anti-androgen		
Second generation Pills containing the progestogens levonorgestrel or norethisterone	Brevinor, Loette, Microgynon 30, Monofeme, Nordette, Norimin, Synphasic, Trifeme, Triphasil, Triquilar	1 in 10,000 women (3 times the normal risk)
Other Pills containing the anti-androgen cyproterone	Diane-35	1 in 10,000 women (3 times the normal risk)
Third generation Pills containing the progestogens desogestrel or gestodene	Femodene, Marvelon, Mercilon, Minulet	2 in 10,000 women (6 times the normal risk)
Combined oral contraceptives containing high-dose oestrogen and progestogen		
Pills containing 50mcg oestrogen	Biphasil, Microgynon 50, Nordiol, Norimin 1-1, Ovral, Ovulen	More than 2 in 10,000 (Actual risk uncertain)

How often are blood clots fatal?

Of those who get a blood clot, 1–2% will die. One death in about two years would be expected in New Zealand women using oral contraceptives.

Up to the end of 1998, at least seven women using oral contraceptives died in New Zealand of a blood clot on the lungs. Five of these deaths occurred in 1997 and 1998. All of those who died were using third generation pills, the first of which became available in 1982. The reason for the higher than expected number of deaths in the recent years is unclear. Sometimes natural fluctuations can cause unexpectedly high or low numbers of events.

What increases the risk of blood clots?

Some of the risk factors for blood clots are a previous blood clot, a close family member who has had a blood clot, bad varicose veins, being overweight, cancer, recent surgery and being immobilised. Women who have had a previous blood clot should not take a contraceptive pill containing oestrogen. You should tell your doctor if any of these risk factors apply to you.

Your risk of having a blood clot can be increased temporarily, for example by a long flight, being immobilised by injury or illness, or by having surgery.

What are the symptoms and what should I do about them?

The symptoms of a blood clot in the leg are swelling, tenderness and pain, but a blood clot may occur without symptoms. Breathlessness occurs with a blood clot on the lungs. These symptoms can also occur for other reasons.

If you are taking an oral contraceptive pill and you develop any of these symptoms you should see a doctor immediately. You should be particularly alert to these symptoms if you have a risk factor for blood clots.

Treatment for blood clots in the legs or lungs is straightforward.

Who can I discuss this information with?

You should discuss your risk of blood clots with your doctor. You have a right to expect your doctor to explain the risks and symptoms to you in a way that you can understand.

Remember that blood clots are rare events in healthy women taking the contraceptive pill. Serious consequences are even more unlikely to occur. Your risk will be reduced even further if you see a doctor immediately if you get any symptom of a possible blood clot.

HP 3257

Published in February 1999 by Medsafe, PO Box 5013, Wellington, New Zealand.
This document is available on Medsafe's Web site: www.medsafe.govt.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

APPENDIX 7

MINISTRY OF HEALTH
MANATU HAUORA

July 1996
(Updated January 1999)

ADVICE FOR WOMEN ABOUT ORAL CONTRACEPTIVES

Consumer Information

This leaflet is for women taking, or thinking of taking, oral contraceptives ("The Pill").

Recent studies have shown some oral contraceptives have a higher risk of blood clots than others. Because of these studies the Ministry of Health has sent new advice to doctors about oral contraceptives.

Women need to talk to their doctor about whether they are taking the pill that is best for them, next time they renew their prescription. Meanwhile women should continue taking the same pill to prevent pregnancy.

Types of oral contraceptives

Most New Zealand women on oral contraceptives take a combined pill containing an oestrogen plus a progestogen. Most of these women use the oral contraceptives containing the progestogens called desogestrel or gestodene. These oral contraceptives have the brand names Femodene, Marvelon, Mercilon and Minulet.

The other commonly prescribed combined contraceptives are the pills containing the progestogens levonorgestrel or norethisterone. These have the brand names Brevinor, Microgynon, Nordette, Synphasic, Triphasil and Triquilar. There are also other combined pills.

Some women take a contraceptive containing only a progestogen. These have no increased risk of blood clots.

Benefits and risks

Each kind of pill has benefits and risks. A woman may find that one pill is better for her than another.

- All oral contraceptives if taken correctly are *very* effective in preventing pregnancy.

- The pills containing desogestrel or gestodene have a higher risk of blood clots than some other pills.
- A woman may find that she feels better or has less side effects while taking one kind of pill than another.
- The pills containing desogestrel or gestodene possibly reduce the risk of heart attack and stroke.
- Contraceptive pills cause a small increase in the risk of breast cancer.
- Contraceptive pills reduce the risk of cancer of the ovaries and womb, pelvic infection and lumpy breasts.

Risk of blood clots

Most oral contraceptives increase the risk of a woman developing a blood clot. But the risk is very small. Pregnancy also increases the risk of developing a blood clot.

Some women have a higher personal risk of blood clots than others. Some of the risk factors are a previous blood clot, a close family member who has had a blood clot, bad varicose veins, being overweight, cancer, surgery and being confined to a wheelchair.

Without the use of oral contraceptives, approximately 1 healthy (non-pregnant) young woman in 30,000 per year will develop a blood clot.

From the recent studies the risk of blood clots for women using the oral contraceptives containing desogestrel or gestodene is 2 in 10,000 per year. The risk with most oral contraceptives that do not contain desogestrel or gestodene is around 1 in 10,000 per year.

In pregnancy the risk of blood clots is 6 in 10,000 per year. This risk is three times greater than the greatest risk with the combined oral contraceptives.

Almost all women who develop a blood clot will recover completely after treatment.

Informed choice

Before being prescribed a contraceptive, women should ask their doctor to explain the benefits and risks for them. The doctor will need to ask about the woman's health to check whether she has any risk factors before advising her which contraceptive she could use. Then the woman and her doctor will be able to choose the best contraceptive for her.

100
APPENDIX 7

Surgery Rooms
Summer. 20/6/00

What you should know about the risks of taking oral contraceptives

This leaflet is for all women taking, or thinking of taking oral contraceptives ("The Pill").

Studies have shown that some oral contraceptives have a higher risk of causing blood clots than others. You should talk to your doctor about what oral contraceptive is best for you, however, in the meantime continue taking your pill to prevent pregnancy.

There are three types of oral contraceptives available in New Zealand.

1. Those containing oestrogen and a progestogen called desogestrel or gestodene e.g. Femodene, Marvelon, Mercilon and Minulet.
2. Those containing oestrogen and a progestogen called levonorgestrel or norethisterone e.g. Brevinor, Microgynon, Synphasic, Tiphasil and Triquilar.
3. Progestogen only contraceptives (mini pill). This type of oral contraceptive does not cause an increased risk of blood clots.

Each type of pill has risks and benefits. You may find that one pill suits you better than another.

Risk of blood clots

Most oral contraceptives increase the risks of developing a blood clot, however, this risk is very small. The pills containing desogestrel or gestodene carry a slightly higher risk of causing blood clots than some other pills, however they may reduce the risk of heart attack and stroke.

Without the use of oral contraceptives, approximately 1 healthy (non pregnant) young woman in 30,000 per year will develop a blood clot.

The risk for women who take oral contraceptives that do not contain desogestrel or gestodene is 1 in 10,000 per year.

The risk for women who take oral contraceptives that contain desogestrel or gestodene has been shown in studies to be 2 in 10,000 per year.

During pregnancy the risk of blood clots is 6 in 10,000 per year. This risk is three times greater than the greatest risk with the combined oral contraceptives.

Almost all women who develop a blood clot will recover completely after treatment.

Please discuss the information in this leaflet with your doctor. Your doctor will need to know if you have any health problems or risk factors for developing blood clots before advising on the best oral contraceptive for you.

Pegasus Medical Group
Putting the care back into healthcare

—

2 (c) *New Zealand Doctor*

—

2 (d) *Healthy Options*

—

3. Other National Publications

Evening Post

'Clot Risk Caution on Some Contraceptives', *Evening Post*, 20 October 1995, p.1.

'Contraceptive Study Fuels Fears', *Evening Post*, 21 October 1995, p.3.

'Costs Cuts Blamed for UK's Pill Move', By Nicholas Maling, *Evening Post*, 23 October 1995, p.1.

'New Pill Cases Follow Warning', *Evening Post*, 24 October 1995, p.8.

'EU Body Faults British Pill Scare', *Evening Post*, 30 October 1995, p.8.

4. International Publications (not necessarily the print media)

In 1995[1] there were five unpublished but important epidemiological studies that investigated the relationship between current oral contraceptive use and venous thromboembolic disease (VTE). These studies influenced the 18 October 1995 decision made by the UK Committee on Safety of Medicines. All five of these studies were published in medical journals by January 1996. The references for these studies are below:

Lancet

'World Health Organisation Collaborative Study of Cardiovascular Disease and Steriod Hormone Contraception. VTE Disease and Combined Oral Contraceptives: Results of an International Multicentre Case-Control Study', *Lancet*, 1995, 346, pp.1575-1581.

'Risk of Idiopathic Cardiovascular Death and Nonfatal Venous Thromboembolism in Women using Oral Contraceptives with Differing Progestagen Components', By H Jick, S. S. Jick, V. Gurewich, M. W. Myers, C. Vasilakis, *Lancet*, 1995, 346, pp.1589-1593.

---

[1] 1995 is the year which is consistently cited as the third generation oral contraceptive controversy. This date, however, can be called into question because women started to die from VTE caused by third generation oral contraceptives in 1993. Indeed, oral contraceptives have been surrounded with controversy since they entered the market in the 1960s. The particular oral contraceptive debate, which is the focus of my thesis, is arguably different (although related) to older oral contraceptive controversies because this new 'scare' stems from different hormones which cause a different disorder (VTE). An important question is who decides what the start date should be for a medical controversy and for what purpose?

'Enhancement by Factor V Leiden Mutation of Risk of Deep-Vein Thrombosis Associated with Oral Contraceptives Containing Third-Generation Progestagen', By KWM Bloemenkamp, FR Rosendaal, FM Helmerhorst, HR Buller, JP Vandenbroucke, *Lancet*, 1995, 346, pp.1593-1596.

'Population Based Study of Risk of Venous Thromboembolism Associated with Various Oral Contraceptives', By RDT Farmer, RA Lawrenson, CR Thompson, JG Kennedy, IR Hambleton, *Lancet*, 1997, 349, pp.83-88.

British Medical Journal

'Third Generation Oral Contraceptives and Risk of Venous Thromboembolic Disorders: An International Case-Control Study', By W. O. Spitzer, M. A. Lewis, LAJ Thorogood, KD MacRae, *British Medical Journal*, 1996, 312, pp.83-88.

1996

1. National Newspapers

1 (a) ***The Press***

—

1 (b) ***The Sunday Star Times***

—

1 (c) ***The Dominion***

'Freephone Disconnected', By Frances Ross, *The Dominion*, 10 January 1996, p.11.

'Abortions Rise After Pill Scare', *The Dominion*, 16 April 1996, p.4.

'Birth Control Pills Safe – Australia', *The Dominion*, 24 July 1996, p.7.

'Blood Clot Risk in Contraceptive Pills', *The Dominion*, 25 July 1996, p.3.

2. National Magazines

2 (a) ***The Listener***

—

2 (b) ***The New Zealand Woman's Weekly***

—

2 (c) ***New Zealand Doctor***

'Low Dose Pill Still Safe Option, Experts Say', By Mary-Anne Aggett, *New Zealand Doctor*, 6 March 1996.

'Mum's the Word on Contraception', By Mary-Anne Aggett, *New Zealand Doctor*, 1 May 1996.

'Pharmac Yet to Decide which Pills will be Free', By Mary-Anne Aggett, *New Zealand Doctor*, 29 May 1996.

'Pill Cleared of Late Cancer Link', By Hugh Paterson, *New Zealand Doctor*, 24 July 1996.

'GPs Left in the Dark', By Louise Pemble, *New Zealand Doctor*, 24 July 1996.

'Softly on the Pill', By Mary-Anne Aggett, *New Zealand Doctor*, 7 August 1996.

'Small Stroke Risk with Low Dose Pill', By Mary-Anne Aggett, *New Zealand Doctor*, 27 November 1996.

2 (d) ***Healthy Options***

'Oral Contraceptives and Blood Clots', *Healthy Options*, August 1996, p.83.

3. Other National Publications

Evening Post

'Pill Safe – Australia', *Evening Post*, 24 July 1996, p.13.

4. International Publications (not necessarily media)

—

1997

1. National Newspapers

1 (a) ***The Press***

—

1 (b) ***The Sunday Star Times***

'Contraceptive Pill Lawsuit Raises Concern', By Ruth Berry, *Sunday Star Times*, 9 February 1997, p.5.

1 (c) ***The Dominion***

—

2. National Magazines

2 (a) ***The Listener***

—

2 (b) ***The New Zealand Woman's Weekly***

'Kiwi Abortions', Donna Fleming, *New Zealand Woman's Weekly*, 23 June 1997, pp.14-16.

'The Pill: Do You Know the Risks?', Donna Fleming, *New Zealand Woman's Weekly*, 25 August 1997, pp.42-43.

'Breast Cancer Risk Factors', *New Zealand Woman's Weekly*, 20 October 1997, p.66.

2 (c) ***New Zealand Doctor***

'Pill Sales Switch After Warning', By Mary-Anne Aggett, *New Zealand Doctor*, 19 February 1997.

'Free Pill Brings Change to Market', By Mary-Anne Aggett, *New Zealand Doctor*, 5 March 1997.

'Subsidised Pill Popular', By Mary-Anne Aggett, *New Zealand Doctor*, 14 May 1997.

'Anatomy of A Decision', By Mary-Anne Aggett, *New Zealand Doctor*, 25 June 1997.

2 (d) ***Healthy Options***

'Natural Fertility Management – What is it all About? Conscious Conception! Preconception Care for Both Parents! Overcoming Fertility Problems! Confident Contraception!' Healthy Options, March 1997, p.61.

'Natural Family Planning: The Non-Chemical, Non-Invasive Alternative', By Annie Oliver, *Healthy Options*, September 1997, p.68.

3. Other National Publications

Evening Post

'Pill-Popping Scary', *Evening Post*, 8 March 1997, p.6.

Evening Standard

'Contraceptive Pill Not Foolproof', *Evening Standard*, 21 October 1997, p.7.

4. International Publications (not necessarily media)

Family Planning Perspectives

'New Study Casts Doubt on the Association Between Third-Generation Pills and Venous Thromboembolism', By M L O'Connor, *Family Planning Perspectives*, July/August 1997, Volume 29, Issue 4, p.192.

Modern Medicine

'Third-Generation Oral Contraceptives are Safe for Most Women', By A N Poindexter, *Modern Medicine*, September 1997, Vol 65, Issue 9, p.58.

Lancet

'End of Line For 'Third-Generation-Pill' Controversy?', By Jan P Vandenbroucke & Frits R Rosendaal, *Lancet*, 19 April 1997, Vol 349, Issue 9059, p.1113.

'Third-Generation Pill Warnings Were Premature', By Anne Szarewski, *Lancet*, 16 August 1997, Vol 350, Issue 9076, p.497.

'Balanced View of Risks of Oral Contraceptives', By Walter O Spitzer, *Lancet*, 29 November 1997, Vol 350, Issue 9091, p.1566.

1998

1. National Newspapers

1 (a) ***The Press***

—

1 (b) ***The Sunday Star Times***

—

1 (c) ***The Dominion***

—

2. National Magazines

2 (a) ***The Listener***

—

2 (b) ***The New Zealand Woman's Weekly***

—

2 (c) ***New Zealand Doctor***

—

2 (d) ***Healthy Options***

---

3. Other National Publications

The New Zealand Herald

'A Century of Two Halves', By Gordon McLauchlan, *The New Zealand Herald*, 21-22 November 1998, p.H1.

4. International Publications (not necessarily media)

Women's Health Weekly

'Contraception', *Women's Health Weekly*, 2 February 1998, p.26.

Journal of Obstetrics & Gynaecology

'The 1995 Pill Scare and its Aftermath: Lessons Learnt', By R. K. Bhathena, *Journal of Obstetrics and Gynaecology*, May 1998, Vol 18, Issue 3, p.215.

Lancet

'Pregnancies and Terminations after 1995 Warning About Third-generation Oral Contraceptives', by Susan S. Jick, Catherine Vasilakis et al, *Lancet*, 9 May 1998, Vol 351, Issue 9113, p.1404.

'Increased Risk of Cerebral Venous Sinus Thrombosis with Third-generation Oral Contraceptives', By S. F. T. M. De Bruijn, J. Stam et al, *Lancet*, 9 May 1998, Vol 351, Issue 9113, p.1404

Journal of Nutritional and Environmental Medicine

'Thrombosis and Heart Attacks with Contraceptive and Menopausal Hormones', By Ellen C. G. Grant, *Journal of Nutritional and Environmental Medicine*, June 1998, Vol 8, Issue 2, p.159.

1999

1. National Newspapers

1 (a) ***The Press***

'Women Still Taking the Pill Despite Deaths', *The Press* (Wellington NZPA), 25 January 1999, p.9.

'Call not to Panic Over Pill Scare', By Katherine Hoby, *The Press*, 26 January 1999, p.6.

'Call to Check Risk Before Taking Pill', By Kathryn McNeil, *The Press*, 9 February 1999, p.3.

'Ministry Stands by Contraceptive Pill', By Kathryn McNeil, *The Press*, 2 March 1999, p.9.

'Concern at Pill Deaths', By Kathryn McNeil, *The Press*, 5 March 1999, p.2.

'Pill Users Panic After Seven Deaths', *The Press* (Wellington NZPA), 8 March 1999, p.9.

'Killer Clots from Pill', By Kathryn McNeil, *The Press*, 9 March 1999, p.13.
'Revival in Drug-Free Sex Methods', *The Press*, 13 March 1999, p.35.

'Blood Clot Victim Advocates Tests Before Pill Prescribed', By Katherine Hoby, *The Press*, 17 March 1999, p.3.

'Pill Use Drops Off', *The Press* (Auckland NZPA), 20 September 1999, p.9.

'New Doubt on Latest Birth Pills', *The Press* (London Reuters), 25 September 1999, p.16.

'Pharmac Phases Out Contraceptive Subsidy', *The Press* (National Briefing NZPA), 29 October 1999.

1 (b) ***The Sunday Star Times***

'Six Die in Women's Health Scandal', By Alexander Miriyana, *Sunday Star Times*, 24 January 1999, p.1.

'Who's To Blame for Pill Deaths?', By Sandra Coney, *Sunday Star Times*, 24 January 1999, p.7.

'Robbed of his Wife', By Alexander Miriyana, *Sunday Star Times*, 31 January 1999, p.1.

'OC Follow-Up Proves a Bitter Pill For Ministry to Swallow', By Sandra Coney, *Sunday Star Times*, 31 January 1999, p.7.

'Doctors Lax Over Pill Advice, Says Coney', By Alexander Miriyana, *Sunday Star Times*, 7 February 1999, p.A4.

'Free Phoneline for Pill Users', By Alexander Miriyana, *Sunday Star Times*, 14 February 1999, p.A6.

'Seventh Woman Dead in Major Pill Scandal', By Alexander Miriyana, *Sunday Star Times*, 28 February 1999, p.A1.

'Drug Firm's Pill Figures Denied', By Alexander Miriyana, *Sunday Star Times*, 7 March 1999, p.4.

'How Many Women have to Die?', *Sunday Star Times*, 7 March 1999, p.10.

'Pill Warning for GPs', By Donna Chisholm, *Sunday Star Times*, 14 March 1999, p.4.

'Ads Rate Women as Bimbos, Says Pill Campaigner', By Alexander Miriyana, *Sunday Star Times*, 21 March 1999, p.7.

'Pill Advice Upsets Husband', By Alexander Miriyana, *Sunday Star Times*, 11 April 1999, p.2.

'Drugs Firm Tried to Stop Pill Warning', By Alexander Miriyana, *Sunday Star Times*, 2 May 1999, p.A1.

'Taking Our Pills Not a Matter of Blind Faith', By Alexander Miriyana, *Sunday Star Times*, 2 May 1999, p.8.

'Fatal Blood Clots Missed by Doctors', By Alexander Miriyana, *Sunday Star Times*, 9 May 1999, p.11.

'Being Informed', By Dr Gill Boddy, *Sunday Star Times* (Wellington), 9 May 1999, p.12.

'Pill Pointer', By Hannah Edwards, *Sunday Star Times* (Auckland), 23 May 1999, p.12.

'Ministry is Dragging the Chain', By Sandra Coney, *Sunday Star Times*, 30 May 1999, p.6.

'Pill Victims' Risk Factors Were Missed: Case Notes', By Alexander Miriyana, *Sunday Star Times*, 30 May 1999, p.8.

'Secret Plans Threaten Drug Safety', By Sandra Coney, *Sunday Star Times*, 6 June 1999, p.4.

'Group Suing Drug Companies on Pill', By Alexander Miriyana, Sunday Star Times, 20 June 1999, p.4.

'Who's Responsible for Pill Problem?', By Sandra Coney, *Sunday Star Times*, 25 June 2000, p.C6.

'Pill Change Rejected', *Sunday Star Times*, 27 June 1999, p.4.

'Picking Up the Pieces After the Pill', By Alexander Miriyana, *Sunday Star Times*, 11 July 1999, p.C5.

'Abortion Fears Unfounded', By Alexander Miriyana, *Sunday Star Times*, 11 July 1999, p.A7.

'Third Generation Pill Use Slump', By Alexander Miriyana, *Sunday Star Times*, 19 September 1999, p.13.

1 (c) ***The Dominion***

'Too Many women on third Generation Pill', *The Dominion* (NZPA), 25 January 1999, p.2.

'Discuss Pill Use Concerns – Doctor', *The Dominion*, 28 January 1999, p.7.

'Debate Over Pill Not so Clear Cut', By Chris Kalderimis, *The Dominion*, 9 February 1999, p.14.

'Don't Panic Women Told', By Joanna Norris, *The Dominion*, 1 March 1999, p.1.

'Anxious Women Overload Helpline', by Cathie Bell, *The Dominion*, 2 March 1999, p.1.

'Warnings Over the Pill Ignored Says King', By Christine Langdon and NZPA, *The Dominion*, 3 March 1999, p.1.

'Many Likely to Stop Using Suspect Pills', By Christine Langdon, *The Dominion*, 4 March 1999, p.3.
'Pill Users Running Scared', By Christine Langdon, *The Dominion*, 6 March 1999, p.1.

'Time to Panic', By Justin Riggir, *The Dominion* (Letters to Editor), 6 March 1999, p.18.

'Pill Fear May Cause Pregnancy Boom', *The Dominion*, 12 March 1999, p.3.

'Doctors Warned on Risk of Legal Action', *The Dominion*, 15 March 1999, p.3.

'Pill Publicity Campaign', *The Dominion*, 19 March 1999, p.2.

'Women Can Swap Pill – Delamere', By Cathie Bell, *The Dominion*, 22 March 1999, p.2.

'Men Cut up by Pill Scare', *The Dominion*, 3 April 1999, p.1.

'Details Sought on Pill Report', *The Dominion*, 6 April 1999, p.3.

'Stance on Pill Safety Backed', *The Dominion*, 10 April 1999, p.7.

'Drug Firm Tried to Stop Pill Warning', *The Dominion*, 3 May 1999, p.3.

'Ministry's Pill Warning Faces Investigation', By Christine Langdon, *The Dominion*, 12 May 1999, p.2.

'Two More Deaths Linked to Pill', By Bernadette Courtney, *The Dominion*, 26 May 1999, p.1.

'Contraceptive Advice Challenged Over Death', *The Dominion* (NZPA), 27 May 1999, p.10.

'Blood Clot Victim was High Risk on Pill – MP', *The Dominion* (NZPA), 27 May 1999, p.10.

'Clot Victims Should Not Have Had Pill', *The Dominion* (NZPA), 31 May 1999, p.3.

'Pill Scare means Rise inAbortions', By Christine Langdon, *The Dominion*, 11 June 1999, p.3.

'Contraceptives Subsidised', *The Dominion*, 19 July 1999, p.3.

'Contraceptive Pill Report Delayed', *The Dominion*, 17 September 1999, p.12.

'Third Generation Pill Use Dives Since Deaths Link', *The Dominion* (NZPA), 20 September 1999, p.11.

'New Doubts About the Pill', *The Dominion* (Reuter), 25 September 1999, p.4.

2. National Magazines

2 (a) The Listener

'In the Blood: The Deaths of Six Women have put third Generation Contraceptive Pills Under the Microscope', By Margo White, *Listener*, 13 February 1999, p.32.

2 (b) The New Zealand Woman's Weekly

'How the Pill Can Kill', By Lisa Turner, *NZWW*, 8 March 1999, pp.20-21.

2 (c) New Zealand Doctor

'Déjà vu Over Pill Story', By Barbara Fountain, *New Zealand Doctor* (Editorial), 3 February 1999.

'Link Between Pill and VTE Deaths Scrutinised', By Mary MacKinven, *New Zealand Doctor*, 3 February 1999.

'At Issue with Pill Story', By MAH Baird, *New Zealand Doctor*, 3 March 1999.

'Pill Review Due', By Mary MacKinven, *New Zealand Doctor*, 17 March 1999.

'Putting 1999 Under the Media Microscope', *New Zealand Doctor* (Feature), 8 December 1999.

2 (d) Healthy Options

'A Bitter Pill To Swallow: The Devastating Risks of Oral Contraceptives', By Sherrill Sellman, *Healthy Options*, July 1999, pp.17-21.

'Natural Birth Control: A Holistic Approach to Contraception', *Healthy Options*, July 1999, p.23.

3. Other National Publications

Evening Post

'Pill Gets the All-Clear in 25 Year Study', By Jeremy Laurance, *Evening Post*, 27 January 1999, p.20.

'Women told To talk to GPs about Pill Blood Clot Risks', By Anne-Marie Johnson, *Evening Post*, 1 March 1999, p.2.

'GPs Told to Warn All Patients of Pill Peril', By Anne-Marie Johnson, *Evening Post*, 10 March 1999, p.1.

'Pill Advice Conflicting for Last Two Years – GPs', By Anne-Marie Johnson, Suzanne Green, *Evening Post*, 11 March 1999, p.3.

'Pill Deaths Spark Interest in Drug-Free Birth Control', By Anne-Marie Johnson, *Evening Post*, 12 March 1999, p.3.

'Third Generation Pills Given OK', By Anne-Marie Johnson, *Evening Post*, 12 April 1999, p.6.

'Blood Clot Victim was on Third Generation Pill', By Bob Shaw, *Evening Post*, 19 April 1999, p.1.
'Wainui Mum Among Blood Clot Dead', *Evening Post*, 23 April 1999, p.2.

'Two More Pill Users Dead – Doctor', *Evening Post*, 26 May 1999, p.2.

Grace

'Birth Control: what Next?', by Dr Roderick Mulgan, *Grace*, February 1999, p.108.

'Women's Deaths Spark Abortion Boom Fears', By Gary Maryvonne, *Truth*, 12 March 1999, p.4.

North & South

'Keep Taking the Pill', By Scott Duffton, *North & South*, May 1999, p.104.

Observer

'Natural Contraceptive Alternative', *Observer*, 23 August 1999, p.22.

Daily News in Taranaki

'Pill Risk Story Unbalanced', *Daily News in Taranaki*, 2 February 1999, p.6.

Southland Times

'Oral Contraceptives Risk is Real But Rare', By Caroline Corkill, *Southland Times*, 2 February 1999, p.7.

'Bitter Pills', *Southland Times*, 2 March 1999, p.6.

'Southland Women go off the Pill', By David Cosgriff, *Southland Times*, 20 March 1999, p.5.

Evening Standard

'Inquiries Flood in from Worried Women on the Pill', By Rachel Forde, *Evening Standard*, 3 March 1999, p.1.

'Better Information Needed on the Pill', *Evening Standard*, 6 March 1999, p.8.

SNE

'Women Turn Off the Pill', *SNE*, 7 March 1999, p.9.

Nelson Evening Mail

'Advice on Pill Risks', *Nelson Evening Mail*, 10 March 1999, p.2.

Ministry of Health Website (www.moh.govt.nz)

'Media Release: Ministry Reinforces Advice on Third Generation Contraceptives', 25 May 1999.

New Zealand GP

'OCs – Emotional Journalism?' By Dr Jennifer Martin, *New Zealand GP* (Letters to the Editor), 7 April 1999, p.13-16.

'The Full Story...', By Dr Karen Poutasi, *New Zealand GP* (Letters to the Editor), 7 April 1999, p.13.

'...Well, maybe not entirely', By Patricia Rasmussen, *New Zealand GP* (Letters to the Editor), 7 April 1999, p.13.

- "Consumer Information" Distributed by GPs

'Advice for Women about Oral Contraceptives: Consumer Information', Ministry of Health, updated January 1999 (first published July 1996).

'Oral Contraceptives and Blood Clots', New Zealand medicines and Medical Devices Safety Authority (MEDSAFE), January 1999.

'The 7 Day Rule', Pegasus Medical Group, January 1999.

4. International Publications (not necessarily media)

Lancet

'Deaths Linked to Third Generation Contraceptives', By Sandra Coney, *Lancet*, 30 January 1999, Vol 353, Issue 9150, p.389.

'Contraceptive Pill Approved in Japan', By Megan Rowling, *Lancet*, 12 June 1999, Vol 353, Issue 9169, p.2048.

'Venous Thromboembolism Among New Users of Different Oral Contraceptives', By RMC Herings, J Urquhart, HGM Leufkens, *Lancet*, 10 July 1999, Vol 354, Issue 9173, p.127.

British Medical Journal

'The Third Generation Oral Contraceptive Controversy', By Paul A O'Brien, *British Medical Journal*, 25 September 1999, Vol 319, Issue 7213, p.795.

International Family Planning Perspectives

'Recent Trends in Abortion Rates Worldwide', By Stanley K Henshaw, S. Singh, T Haas, *International Family Planning Perspectives*, March 1999, Vol 25, Issue 1, p.44.

2000

1. National Newspapers

1 (a) *The Press*

'Health Miracles', Professor Andrew Hornblow, *The Press*, 1 January 2000, p.27.

'Abortions at Record Level', *The Press* (Wellington NZPA), 9 June 2000, p.8.

'Abortion Rise After Scare', By Victoria Clausen, *The Press*, 12 June 2000, p.6.

'Calm Urged as Pill Deaths Totted Up', By Diana McCurdy, *The Press*, 17 June 2000, p.1.

'Call for more Money to Monitor the Pill', *The Press* (Wellington NZPA), 19 June 2000, p.19.

'Contraception Should be More Critically Prescribed', By Victoria Clausen, *The Press*, 20 June 2000, p.3.

1 (b) *The Sunday Star Times*

'Drug Companies to Testify at Pill Inquest', By Alexander Miriyana, *Sunday Star Times*, 18 June 2000, p.5.

1 (c) *The Dominion*

'Pill Deaths – Who is at Risk?', By Sarah Prestwood, *The Dominion*, 17 June 2000, p.1.

2. National Magazines

2 (a) *The Listener*

—

2 (b) *The New Zealand Woman's Weekly*

'Could Taking the Pill Kill?', By Donna Fleming, *New Zealand Woman's Weekly*, 3 July 2000, pp.20-21.

2 (c) *New Zealand Doctor*

—

2 (d) *Healthy Options*

—

3. Other National Publications

Christchurch Star

'Contraceptive Use', By W. D. Pascoe, *Christchurch Star* (Readers' Letters), 12 January 2000, p.A6.

'Rise in Abortion Rate Sad', By K OSMERS, editor Men for Equal Rights Association, *Christchurch Star*, 19 July 2000, p.A6.

'Caution Urged Over Pill', By K ORR spokesperson Society for the Protection of the Unborn Child, *Christchurch Star*, 19 July 2000, p.A6.

Observer

'Contraception for the 90's', *Observer*, 21 February 2000, p.26.

'Natural Family Planning: A Safe Contraceptive', *Observer*, 24 April 2000, p.17.

Consumer

'Problems with the Pill', *Consumer*, March 2000, Issue 390, pp. 10-11.

* *Ministry of Health Website*: http://www.moh.govt.nz

'Deaths From Third Generation Oral Contraceptives'.

* *Pegasus Medical Group Consumer Information*
'What you Should Know About the Risks of Taking Oral Contraceptives', undated but collected from Sumner Medical Rooms on 20 June 2000.

Metro

- ***Metro*** has not published any articles on the third generation oral contraceptive debate and does not intend to at this stage (see email correspondence with *Metro* editor, 17 July 2000).
- *Listener* has no "immediate plans" to publish another story on the third generation oral contraceptive controversy (see email correspondence with *Listener* 18 July 2000).

4. International Publications (not necessarily media)

Health Facts

'Birth control Pills: Which Type is Best?', *Health Facts*, June 2000, Vol 25, Issue 6, p.2.

Population Reports

'Health Risks of Oral Contraceptives', *Population Reports*, Spring 2000, Vol 28, Issue 1, p.13.

APPENDIX 9

CHRONOLOGY OF PRINT MEDIA TEXTS ON ORAL CONTRACEPTIVES BEFORE 1995 LISTED BY DATE AND PUBLICATION

1994

The Dominion

'Pill Back Under Suspicion', By Nigel Hawkes, *The Dominion*, 14 June 1994, p.3.

1993

—

1992

—

1991

New Zealand Woman's Weekly

'What Contraception Should I Choose?', By Leigh Parker, *New Zealand Woman's Weekly*, 14 January 1991, pp. 46-47.

1990

The Dominion

'Weighing up the Pill Thirty Years on', By Ann Kent, *The Dominion*, 16 April 1990, p.11, (additional reporting from 'Doctors Clash in the Big Controversy on Contraception – The Pill: Three New Warnings Given', *The Times*).

New Zealand Woman's Weekly

'Lowering the Pill's Risks', By Jennifer Little, *New Zealand Woman's Weekly*, 28 May 1990, pp.44-45.

The Listener

'Perfecting the Pill', By Peter Radetsky, *Listener and TV Times*, 1 October 1990, pp.106-107.

1989

—

1988

—

1987

New Zealand Woman's Weekly

'Family Planning...The Natural Way', By Rosemary Vincent, *New Zealand Woman's Weekly*, 14 December 1987, pp.42-43.

From the release of Oral Contraceptives onto the market (1960s) to 1986

Broadsheet canvasses many oral contraceptive, and other medical controversies, pertaining – approximately - to the aforementioned dates.

APPENDIX 10

CHRONOLOGY OF PRINT MEDIA COVERAGE OF OTHER MEDICAL AND ESPECIALLY CONTRACEPTIVE CONTROVERSIES - LISTED BY DATE

1987

'An Unfortunate Experiment at National Women's Hospital', By Phillida Bunkle and Sandra Coney, *Metro*, June 1987, pp.46-65.

1988

'Next Stop...A Pill For Men?', By Sandra Goodwin, *New Zealand Woman's Weekly*, 16 May 1988, pp.52-53.

1989

'A Link Between Depo-provera and Cancer?', By Glenys Bowman, *New Zealand Woman's Weekly*, 13 November 1989, pp.32-33.

'New Pill Could be a Cocktail of Hope', By Alan Burns, *New Zealand Woman's Weekly*, 13 November 1989, p.34.

1990

'Profit and the Pill', By Gordon Campbell, *Listener*, 12 February 1990, pp14-17.

'Women at Risk: The Dangers of Depo-provera', By Sandra Coney, *Listener*, 12 November 1990, pp.10-15.

'The Claims Against the Copper 7', By Phillida Bunkle, *Listener*, 10 December 1990, pp.10-15&108.

'Copper 7: The Company Response', By Kay Bruno, *Listener*, 17 December 1990, pp.19-20.

'Women at Risk', *Listener* (Letters to the Editor), 17-23 December 1990, pp.84-85.

1991

'An Abortion Pill for NZ Women?', By Leigh Parker, *New Zealand Woman's Weekly*, 21 January 1991, pp.44-45.

'Covering Up With Condoms', By Gordon Campbell, *Listener*, 23 September 1991, pp.20-23.

'Copper 7 Users Ready to Fight', By Rosemary Vincent, *New Zealand Woman's Weekly*, 20 April 1992, p.66.

1992

—

1993

—

1994

'If Only Someone Had Warned Me', By Julie, *HealthyOptions*, February 1994, pp.49-50.

1995

—

1996

—

1997

'Bill's Baby: The New Health Minister May Block Abortion Drugs on Principle', By Gordon Campbell, *Listener*, January 25-31 1997, pp.28-30.

'My IUD Nightmare', By Donna Fleming, *New Zealand Woman's Weekly*, 22 September 1997, pp.20-21.

1998

'Secret Lives', By Pamela Stirling, *Listener*, 14-20 February 1998, pp.30-32.

'Investigate the Body: Get the Inside Story of the Human Body from Conception to Death – And After', By Margo White, *Listener*, 26 September-2 October 1998, pp.68-70.

'A Theory of Everything', By Ben Marshall, *Listener*, 19 December 1998, pp.30-31.

1999

'Oestrogen Rising', By Noel O'Hare, *Listener*, 16 January 1999, p.46.

'Seed Money: Equal Reproductive Rights for Men, Say Some Groups', By Nick Smith, *Listener*, 10 April 1999, pp.34-35.

'Shot in the Dark', By Marianne Betts, *New Zealand Woman's Weekly*, 12 July 1999, p.20-21.

'Natural Attractions', By Noel O'Hare, *Listener*, 24 July 1999, pp.17-21.

'Big E', By Aimee Lee Ball, *Harpers Bazaar*, August 1999, pp.154,169-170.

2000

'The Creative Power of Thought', By John Campbell, *The Press*, 1 January 2000, p.58.

'Bishop for Contraception', *The Press* (Auckland NZPA), 17 April 2000, p.9.

'Men on the Pill', By Sheryl Blythen, *She Magazine*, May 2000, p.111.

'Warning Attached to New Morning After Pill', *The Press* (Wellington NZPA), 2 June 2000, p.9.

'Pill For 24-Hour Sex', *The Press* (Reuters), 12 June 2000, p.12.

'Blueprint to Improve Women's Lot', *The Press* (New York Reuters), 12 June 2000, p.11.

'Abortion Pill Gains Support: Medics Want to Offer Choice', By Ruth Laugesen, *Sunday Star Times*, 25 June 2000, p.1.

'Abortion Pill to be Tested', *The Press* (Wellington Reuters), 26 June 2000, p.5.

'Fighting for a Woman's Right to Choose', by Lin Ferguson, *Sunday Star Times*, 2 July 2000, p.C5.

'Abortion Research Criticised', By Kathryn McNeil, *The Press*, 20 August 2000, p.2.

'Contraceptive Implant', *The Press* (Wellington NZPA), 17 November 1999, p.6.